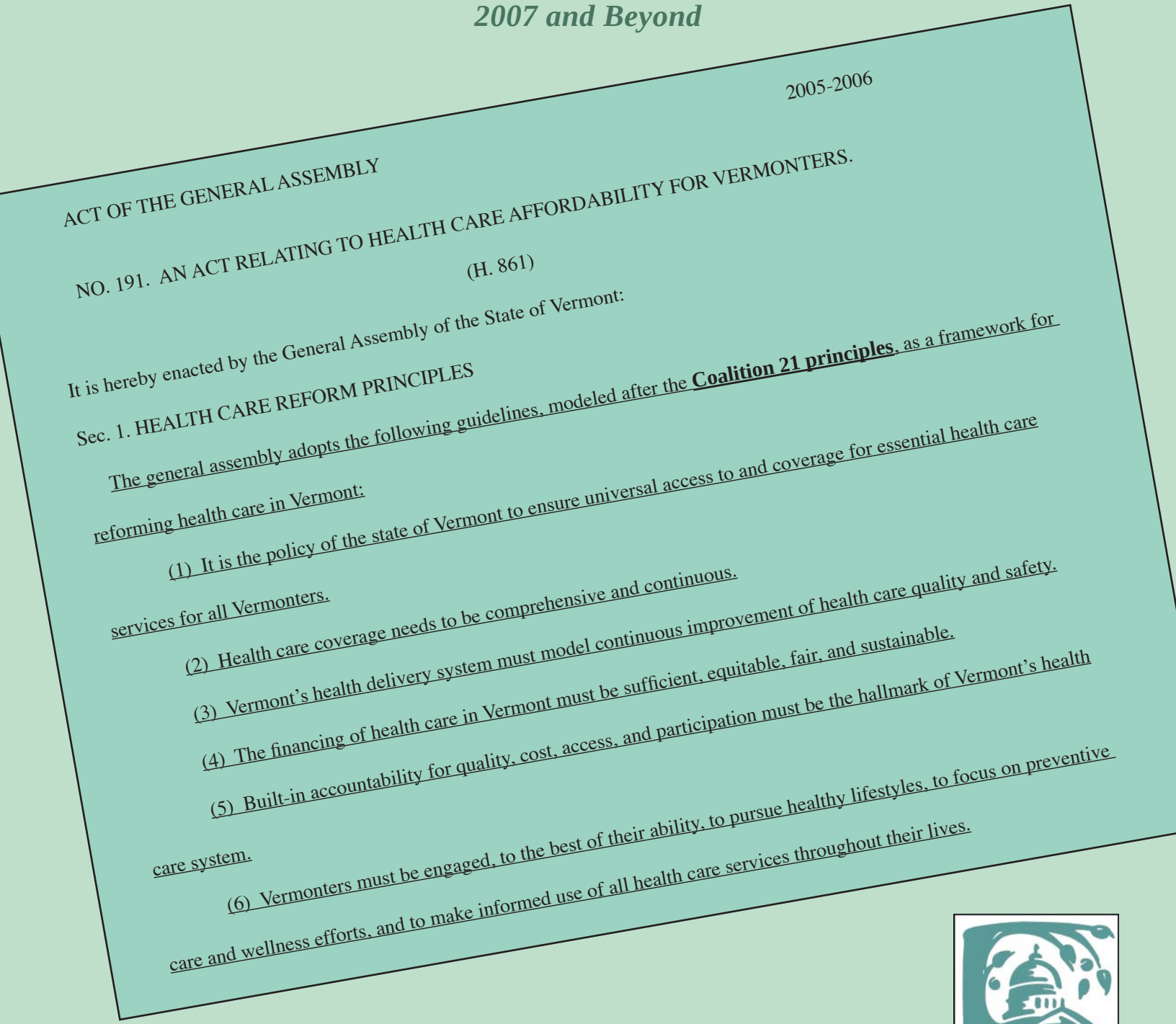
# *Health Care Reform in Vermont*
# *Hard Choices for Transformative Change*

## *Coalition 21—An overview of its work and perspectives of members on what lies ahead. 2007 and Beyond*



ACT OF THE GENERAL ASSEMBLY 2005-2006

NO. 191. AN ACT RELATING TO HEALTH CARE AFFORDABILITY FOR VERMONTERS.

(H. 861)

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. HEALTH CARE REFORM PRINCIPLES

The general assembly adopts the following guidelines, modeled after the **Coalition 21 principles**, as a framework for reforming health care in Vermont:

(1) It is the policy of the state of Vermont to ensure universal access to and coverage for essential health care services for all Vermonters.

(2) Health care coverage needs to be comprehensive and continuous.

(3) Vermont's health delivery system must model continuous improvement of health care quality and safety.

(4) The financing of health care in Vermont must be sufficient, equitable, fair, and sustainable.

(5) Built-in accountability for quality, cost, access, and participation must be the hallmark of Vermont's health care system.

(6) 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.

**Prepared by Glenn McRae**
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SNELLING CENTER FOR GOVERNMENT
AT THE UNIVERSITY OF VERMONT

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# COALITION 21: Transforming Health Care for the New Century

**2004-2006**

**Members**

**Chairman:** Stephan Morse, President and CEO, The Windham Foundation, Inc.

**Senator Jim Leddy,** Vermont State Legislature, Senate Health and Welfare Committee
**Representative John Tracy,** Vermont State Legislature, House Health Care Committee
**Representative Tom Koch,** Vermont State Legislature, House Human Services Committee

**Lisa Ventriss,** President, Vermont Business Roundtable
**Otto Engelberth**, CEO, Engelberth Construction
**Con Hogan,** former Secretary, Vermont Agency of Human Services

**AARP-Vermont,** Philene Taormina, Associate State Director for Advocacy
**Bi-State Primary Care Association,** Tess Stack Kuenning, Executive Director
**Blue Cross Blue Shield of Vermont,** Kevin Goddard, VP Marketing and External Affairs
**Community of Vermont Elders,** Betsy Davis, President
**Lake Champlain Regional Chamber of Commerce**, Wayne Roberts, President
**MVP Health Care, Vermont Region,** Jim Hester, Vice President, Vermont
**Vermont Association of Hospitals and Health Systems**, Bea Grause, President
**Vermont Alliance of Nonprofit Organizations,** Jane Van Buren, Executive Director
**Vermont Business Roundtable,** Mark Neagley, Chairman of the VBR's Health Care Working Group
**Vermont Businesses for Social Responsibility**, Leslie Nulty, Public Policy Committee
**Vermont Chamber of Commerce**, Duane Marsh, President
**Vermont Citizens Campaign for Health**, Richard Davis, Executive Director
**Vermont Coalition for Disability Rights,** Lila Richardson
**Vermont Council of Developmental and Mental Health Services**, Julie Tessler
**Vermont Ecumenical Council and Bible Society**, The Rev. Rick Neu, President
**Vermont Health Care Association,** Mary Shriver, Executive Director
**Vermont Health Care for All,** Dr. Deborah Richter, Chair
**Vermont Low Income Advocacy Council** (Vt. Legal Aid), Donna Sutton Fay
**Vermont Medical Society,** Paul Harrington, Executive Vice President
**Vermont NEA,** Mark Hage, Director of Member Benefits
**Vermont Program for Quality in Health Care ,** Helen Riehle, Executive Director
**Vermont State Labor Council (AFL-CIO),** Dan Brush
**Vermont State Employees' Association,** Terry Macaig
**Vermont State Nurses' Association, Inc**., Peggy Sharpe, Director

Staffing for the Coalition was provided by:
**Glenn McRae, The Snelling Center for Government**

This publication is a summary of the work of Coalition 21 and lays out the perspectives of some of the members on the contributions of the coalition to the process of health care reform in Vermont after the passage of Catamount Health in 2006.

(March 2007)

Health Care Reform in Vermont - Hard Choices for Transformative Change.

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2007 and Beyond

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# Health Care Reform in Perspective

## *We have been in this conversation for a long time*

**1923** - Vermont Department of Health established

**1930** - 121 Vermont towns without doctorin residence

**1944** - Blue Cross/Blue Shield formed in Vermont - New Hampshire

**1945** - Governor Proctor established Advisory Health Committee to write state health plan

**1948** - First of annual state health plans for hospitals and health centers

**1960** - 169 Vermont towns with doctor in residence - described as "shortage"

**1965** - Governor Hoff appoints Advisory Board on Health Programs

**1967** - Vermont House forms Health and Welfare Committee

**1967** - Committee on Comprehensive Health Planning established by Governor Hoff

**1968** - Vermont Comprehensive health planning agency established in the Governor's office

**1968** - Federal mandate establishes a Vermont state-wide comprehensive Health Planning Agency

**1969** - Vermont Senate forms Health and Welfare Committee

**1970** - Cooperative health information center of Vermont opened

**1973** - Governor Salmon appoints Daniels Commission on Health Care in Vermont

**1975** - Daniels Commission report issued and Health Care Cost Commission established

**1976** - Health Policy Council established

**1977** - Governor Snelling establishes Health Policy Corporation

**1980** - Governor Snelling establishes Kitchell Commission on Hospital Costs

**1983** - Report on Health Care Costs in Vermont published by Agency of Human Services

**1984** - Windham Foundation Conference on Future of Health Care in Vermont

**1987** - Vermont maintains Health Policy and Data Councils without federal mandates

**1987** - Governor Kunin initiates state-wide health planning by Health Policy Council and Health Data Council

**1988** - Study of uninsured in Vermont

**1988** - Vermont Program for Quality in Health Care established

**1991** - Windham Foundation Conference on Vermont Health Care for the 1990s

**1991** - 45,000 uninsured Vermonters identified

**1991** - Governor Snelling appoints the Gibb Commission on Hospital Costs

**1992** - Health Department publishes "Healthy Vermonters 2000"

**1992** - Health Care Authority replaces the Policy Council, Data Council and C.O.N. Review Board

**1993** - Governor Dean establishes the Commission on Public Health Care Values and Priorities

**1993** - Vermont House Speaker Ralph Wright appoints special Legislative Health Committee

**1994** - Health Care Authority presents report on two Universal Access Plans for Vermonters

**1995** - Office of Vermont Health Access is formed

**1995** - Health Care Authority publishes "Guide to Health Care Reform"

**1997** - Commission on Public's Health Care Values & Priorities issues first report

**1997** - Office of Health Omsbudsman authorized

**1998** - Medicaid eligibility for children expanded

**1999** - Independent assessment of Vermont health care system authorized

**2000** - Governor Dean appoints "Hogan" commission

**2000** - Vermont Health Department publishes "Healthy Vermonters 2010"

**2001** - Lewin report published on extending health insurance to Vermont's uninsured

**2001** - Hogan Commission issues report on Health Care Availability and Affordability

**2001** - Commission on Public's Health Care Values & Priorities issues second report

**2001** - Health Access Oversight Committee forecasts growing Medicaid shortfall

**2004** - "Blueprint for Health" report is issued with emphasis on chronic care

**2004** - Act 53 calls for new Health Resource Allocation Plan and State Health Plan

**2004** - Broad-based "Coalition 21" begins work toward establishing principles of reform

**2005** - Vermont House establishes Health Care Committee

**2005** - Vermont Legislature develops public engagement process on health care reform, and Governor Douglas hosts a series of hearings around the state

**2006** - Vermont Legislature passes a set of reforms including "Catamount Health." Governor signs Acts into law.

**2007** - "How will Vermonters remain engaged and part of making reform happen in Vermont?"

***It is your choice to take this into the future. It is up to you to stay informed and engaged so that reform that happens is what best serves Vermonters and matches our values.***

# Overview of Coalition 21
# Members, Mission, and Principles

Coalition 21 was created in July, 2004, to forge a consensus regarding how to transform Vermont's health care system. That system is changing rapidly, and most trends are heading in the wrong direction. Securing good health care at a realistic cost has become increasingly difficult for Vermonters. The goals of providing affordability, accessibility, and quality that have been at the center of system changes for the past two decades still elude us.

This document has been developed to sum up the work of the coalition as a collaborative effort to bypass some of the barriers that plague transformative change. The coalition is no longer active and, whether it is viewed as a failure or a partial success in meeting its stated goals, its contributions to facilitating movement in the debate are not insignificant. The contributions that follow are meant to provide documentation of what Coalition 21 attempted, what it accomplished, and how some of its members—through the lens of this experience—see the work continuing into the future.

The difficult work of moving toward a well-coordinated transformation of the health care system—one that encompasses the entire system, covering all Vermonters—necessitates that the many diverse interest groups remain in active conversation and working relationship with one another, as well as with the legislature and the administration. Whether Coalition 21 exists or not, the work ahead requires that all of these interests continue to come forward or be brought to the table as steps are taken.

Some of the beliefs that Coalition 21 established still ring true for the future:

- The health care "system" at present does not operate as a complete and integrated system, and this accounts for several challenges in creating change that require payers, providers, citizens, regulatory institutions,and administrative units to work together.
- The system must be organized and operated as a cohesive and unified whole in order for successful change to be implemented. Any real effort at change must take on the difficult task of keeping all the pieces together, using a coordinated deliberative process that models a system that will serve Vermonters best.
- The changes to the health care system must be system-wide, initiated across the board, in a coordinated fashion. Piecemeal or stand-alone measures that affect only some groups will not be sufficient or equitable.
- Mechanisms for system changes must be established to transcend the two-year political cycle if the system is to be transformed and set on a sustainable course, in line with principles such as those developed by the coalition, in service of all Vermonters.

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The Snelling Center for Government was asked to staff the coalition. It provided facilitation and organizational support, conducted research, coordinated communications between the stakeholders, and documented the progress and outcomes of Coalition 21 efforts. The information used by the coalition, and the results of its work are available at:

http://www.snellingcenter.org/public-policy/library/

Background information and continuing work at the legislature and state government are available at:

http://www.leg.state.vt.us/HealthCare/default.htm

## Principles of Health Care System Change for Vermont in the 21st Century

***In January, 2005, twenty-four diverse interest groups representing a broad array of business, health care, consumer, and other professional concerns achieved a consensus that Vermont will be well served by using the following principles to guide health care reform. Shortly thereafter, the House Health Care Committee adopted these principles to guide and inform their work in the 2005-2006 biennium. The principles were embedded in legislation proposed and finally signed into law in 2006.***

**Principle I:**
**It is the policy of the State of Vermont to ensure universal access to and coverage for essential health care services for all Vermonters.**

Universal access means the absence of barriers to essential health care services.

Access needs to be equitable. Vermonters will have coverage for essential services that are delivered in the same high quality manner, regardless of economic or geographic situations.

A critical social policy goal requires that all Vermonters have health coverage and that all Vermonters actively participate in the health system.

**Principle II:**
**Health care coverage needs to be comprehensive and continuous.**

Coverage for essential health services needs to follow the individual from birth to death, and be responsive and seamless through employment and life changes. Vermonters will have access to high quality care throughout their lives.

**Principle III:**
**Vermont's health delivery system will model continuous improvement of health care quality and safety.**

Continuous improvement in health care quality and safety will be integrated into the operation of the health care system, drawing on and promoting evidence-based and best practices, striving for optimal outcomes for the resources expended. Wellness and public health initiatives that promote healthy lifestyles and preventive care are essential foundations of the health system. The health care system will promote care that is safe, timely, effective, patient-centered, efficient, and equitable.[1]

**Principle IV:**
**The financing of health care in Vermont will be sufficient, equitable, fair, and sustainable.**

Universal access to a continuous and comprehensive package of essential high quality health care is a public good. The financing mechanism for attaining a workable, affordable, and sustainable health care system needs to be adequately and fairly funded, and operated in a manner that ensures both high quality of care and efficient use of resources.

**Principle V:**
**Built-in accountability for quality, cost, access, and participation will be the hallmarks of Vermont's health care system.**

The health system will be accountable to the people it serves in respect to the quality of care and the management of costs.

**Principle VI:**
**Vermonters will 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.**

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[1] Institute of Medicine, *Crossing the Quality Chasm*, 2001: 39-40. Six Aims for Health Care Improvement:

- ***Safe*** - avoiding injuries to patients from the care that is intended to help them.
- ***Effective*** - providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit (avoiding under use and overuse, respectively).
- ***Patient-centered*** - providing care that is respectful of and responsive to individual patient preferences, needs, and values, ensuring that patient values guide all clinical decisions.
- ***Timely*** - reducing waits, and sometimes harmful delays, for both those who receive and those who give care.
- ***Efficient*** - avoiding waste, in particular waste of equipment, supplies, ideas, and energy.
- ***Equitable*** - providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

## Coalition 21 – Promise and Legacy
### Jim Leddy and Lisa Ventriss

When Senator Jim Leddy became chair of the Health and Welfare Committee in January 2003, he realized if there were to be any health care reform—as many wanted—he needed to understand why previous efforts, most notably in the early 1990's, had failed. And what had changed in the intervening years that would now lead to a different outcome.

What was clear was that problems of access and cost had only worsened over the years. What was less obvious—but ultimately critical for Leddy—was that a different approach would be necessary, one that would engage a broad spectrum of Vermonters (employers, labor, insurers, providers, advocates) in an effort to find common ground and solutions to a problem and a need that affect everyone. He also believed that such an alliance could be more effective if it were independent of government. The first step was to find a partner.

Since 2002, the Vermont Business Roundtable had identified health care reform as one of its top policy initiatives. Among the members' chief concerns were that medical costs had increased 88 percent during a period when overall inflation was in the low single digits; and that, for all the resources devoted to health care in the state, 10 percent of Vermont's citizens still had no health insurance. The policy question for Roundtable members was "How can we control the rate of health care inflation while, at the same time, making all Vermonters healthier?"

In spring 2004, Senator Leddy approached Roundtable president Lisa Ventriss to explore the possibility of jointly convening a grass roots and broad-based coalition to develop a sustainable plan to transform Vermont's health care system. Leddy's interest was to create a more effective vehicle to address the current and impending problems by finding as much common ground as possible, rather than pursuing multiple separate—and often conflicting—paths. Leddy also wanted to address the growing number of uninsured Vermonters.

From the Roundtable's perspective, discovering ways to provide better access to the highest quality of health care possible for all Vermonters was an interest. Together, they believed that, through well-orchestrated reform, the then-current level of health care spending could obtain far better results for Vermonters.

The goals were laudable, the leadership was committed and even-handed, and expectations were cautiously optimistic that something unique could be accomplished using this consensus-based model. The first year witnessed a retreat, during which time members came to know and understand each other's perspectives; and, most importantly, they developed a set of guiding principles that ultimately were the most valuable work produced by the coalition itself. When Stephan Morse, Chair of Coalition 21, presented these principles to the newly created House Health Committee in January 2005, the committee unanimously embraced the 6 principles and ultimately adopted them verbatim in the bill that became law.

In hindsight, where the coalition failed was in the size and composition of the group itself. Since it was designed as a consensus-based entity, its membership was not carefully balanced among business and other constituencies. So it became clear, during the second year of the biennium, that people could no longer 'leave their guns at the door,' and the process failed to produce further agreement around specifics of health care reform. According to Leddy, another factor limited the ongoing role and effectiveness of the coalition: He believes that the development of the guiding principles helped empower the legislature to action and it jump started the actual legislation. The resulting pace and direction of the legislature's action paradoxically limited the future role and voice of the coalition. In addition to the differing perspectives of coalition members as to how best to implement the principles, it became obvious that a coalition of volunteers with limited staff resources simply could not keep pace with a legislature that was fully engaged and staffed (including consultants). Politics and resources thus prevented the coalition from fulfilling its original intention.

In the great scheme of things, however, the process and lessons learned were very valuable. Where there was no leadership, the coalition provided leadership. Where there was no outside-in, bottom-up process, the coalition provided such a process. And, individually and collectively, participants helped to craft a set of reform recommendations that were based upon the principles that the coalition crafted. Therein is the legacy of Coalition 21.

*Jim Leddy is a former state senator from Chittenden County and chair of the Senate Health and Welfare Committee and co-chair of the legislature's Commission on Health Care Reform.*

*Lisa Ventriss is President of the Vermont Business Roundtable.*

## The Necessity of Building a Collaborative Environment

### Stephan A. Morse, Chair, Coalition 21

In my many years involved in public policy, I do not recall a more bold effort to bring disparate points of view together around a challenging Vermont public policy issue. Vermont has a long history of facing important and difficult public policy issues and coming to resolution, but health care has plagued the state for years. Certainly, Lisa Ventriss of the Vermont Business Roundtable and Senator James Leddy of Chittenden County should be recognized for their vision in bringing some thirty different points of view together. While all parties entered the process with a fair amount of skepticism, they agreed to be part of this effort out of their frustration over the failure to solve this huge issue. They, too, deserve our appreciation. All these folks have spent countless hours over the years attempting to provide quality health care for all Vermonters.

It was certainly an honor to chair the coalition. While I often joked that I was approached in a weak moment, I was enticed by the breadth of the membership and the sincerity of the group in its pursuit of a resolution to our long-standing health care dilemma. Clearly, this was a Vermont crisis and the members realized a solution would only come out of a unique and open process. It was proposed early on that the coalition operate on a "consensus basis." The more normal "majority rule" was not going to serve our purposes. The only way we could be effective would be if all could agree on the scope of the problem and the eventual remedy. This approach was foreign to most participants, who had previously participated in or watched more democratic processes. However, all could plainly see from the outset that consensus gave a fair amount of power to each coalition member. Furthermore, it was not lost on the members that if such a diverse group could possibly agree on a solution, it would be a very powerful force before the Vermont legislature, the administration, and the general public.

As President of the Windham Foundation hosting Grafton Conferences on Vermont public policy issues, I had employed the "consensus approach" successfully. I had witnessed, in conducting over thirty conferences, that it was possible to bring people together through this method. Obviously, it only works when the participants are truly committed to solving a particular issue. If one individual does not share the need for resolution, he or she can disrupt the whole process. Fortunately, all the members of Coalition 21 entered into the process committed and truly wanting to be part of the solution.

The process was slow and did not come easily. All the participants had labored for years in the field and held very passionate positions. A number had been involved in previous abortive efforts at health care reform in Vermont over the past two decades. In addition, many of the participants had faced other

members in adversarial proceedings on health care and other issues. There was not a lot of trust among the members at the start. It took several meetings for the participants to begin to view each other as committed Vermonters with different points of view. The differences were known and understood from the beginning, but it took time for the members to fully understand and appreciate one another.

The public and those on the outside never fully understood the significance of this coalition. The group was looked upon with great mistrust by those on the outside. It was common for interested parties to look at the list of members and count more "single payer" advocates and assume that this was just another single-minded organization. Few on the outside truly believed that the "consensus model" was functional. The lack of support and the unwillingness of some undoubtedly contributed to the failure of the coalition to hold together in the end. It was difficult for some individual participants who were receiving pressure from those in office and from members of organizations that they represented. While the participants labored through the process with the hope of great success, very little credibility was given the endeavor by others. This made the process difficult for many participants.

Perhaps the single most important contribution the coalition brought to the debate was the adoption of the "Six Guiding Principles." These did not come easily to all of the participants. Many members needed to be convinced and, in some cases, they took on different viewpoints from those they held when they entered the process. In adopting these principles, it gave coalition members an opportunity to get to know and trust other members. It is interesting to note that these principles were included in the legislation that eventually passed. If the coalition had survived, these principles would have served as a sound base for further proposals needed to continue advancing reform efforts.

In my opinion, the fractious debate of the 2005 legislative session, resulting in the gubernatorial veto of H.524, made it clear that the work of Coalition 21 was not going to result in success. During those weeks of legislative debate and wrangling with the Douglas administration, all the various coalition participants were forced to return to their advocacy positions. The hopes of a consensus coming together around one health care plan vanished in that climate. After months of meetings, the coalition was not strong enough to survive the heated debate. Some would argue that it was unfortunate that the legislature forced the issue and enacted the law, resulting in a predictable veto.

It is argued that, given more time, the coalition would have presented a proposal with broad-based support. It was clear to me and some of the other members that the coalition could not reorganize after being forced to participate in the heated legislative debate. In my opinion, members could not be adversaries at the State House one day and then return to coalition the next.

As stated elsewhere in this report, many members of the coalition continued to meet, but the broad-based coalition ended in June 2005. The participants are to be commended for their commitment to finding a cooperative resolution to a crucial public policy issue.

It was a pleasure to serve as the Chairman of Coalition 21. While our goals were lofty and we did not succeed in the end, I believe this organization contributed greatly to the eventual success of bold new health care legislation. The fact that thirty very different organizations and individuals could gather monthly to help solve a Vermont crisis, I believe, laid the groundwork for the eventual Catamount Health Plan. Vermont, once again, is leading the nation in grappling with difficult issues. It is not surprising to me that Vermonters representing thirty different points of view gathered together for the common good. That is the Vermont Way.

*Stephan A. Morse is the President and CEO of The Windham Foundation in Grafton, Vermont.*

## The Basic Principles of Working Together as Coalition 21

*The individual work of all of the members of the coalition, in formulating the thinking and positions of their stakeholder groups, will continue alongside the work they are doing within the coalition. The bottom line, however, is that we all support a PROCESS that will ultimately lead us to some consensus recommendations for significant actions to change the system.*

*We all agree with three core statements of principle that all coalition members were asked to accept if they wished to participate, including:*

- *We have a crisis in health care;*
- *Every Vermonter should have health care insurance; and,*
- *We agree to participate and be open to dialogue and to the ideas of others, regardless of our own ideas as to the causes and solutions to the problems.*

*At the first meeting of the coalition, a basic set of ground rules and operating principles were introduced and accepted. These included:*

- *Coalition 21 will create and maintain a fair and open process for its work and for conversations regarding its mission of transforming health care in Vermont. It will balance this process with the need to establish and maintain a "working group" of appropriate size and representation.*
- *Coalition 21 will operate through generally accepted democratic processes and, where warranted, will have discussion and decisions guided by parliamentary procedures overseen by the chair.*
- *Coalition 21 may chose to vote on certain issues, but in general, especially on issues of substance in regard to its mission, it will strive for consensus.*
- *Coalition 21 members agree that the only way for this conversation to move forward and for meaningful change to be developed and advanced is for members to 'check their guns at the door.' Members are encouraged to bring their passion, knowledge and beliefs to the table, but also to agree that listening is the first priority, and respect for differences the only way to reach reasonable solutions.*
- *Coalition 21 meetings and gatherings will allow for public access, and space for participation as appropriate. Other forums to broaden the input into this discussion will be created as necessary and possible.*

## Catamount Health: One Step Forward

**John Tracy**

*"Health care is cheap; sick care is expensive."*

That message was written at our public hearing on health care reform held in Springfield in October 2005. The members of the House and Senate Health Committees took the message to heart and created Catamount Health with the intention of providing Vermonters the right care at the right place at the right time. The goal of Catamount Health was to start to control the rate of growth in health care spending. The goal will be achieved in two ways: by providing people with primary care, and by managing chronic disease.

The two years that I chaired the House Health Care Committee were a time of intense learning for me, for the committee, and for the legislature as a whole. While some of the learning now appears to be common knowledge, trying to learn it in a way that it could be assembled into a cohesive package was a monumental task.

The work of Coalition 21 laid the ground work for our efforts and essentially jump-started our process. It is safe to say that the months of hard work by Coalition 21 to adopt the "Six Guiding Principles" saved our committee months of work in a compressed legislative schedule. The committee did spend a good amount of time debating the principles, considering language changes, and making sure we understood the intent of the language. Ultimately we agreed as a committee that the "Six Guiding Principles" were right on the mark, and we posted them in our committee for the two years of labor that followed.

An early lesson illustrated over and over again was that when people do not have primary care, we all pay the bill. A visit to a primary care doctor costs less than a visit to the emergency room. An ounce of prevention costs a lot less than a pound of cure. Yet when people do not have health coverage, they will put off going to see a doctor until something is wrong. As a result, the place of treatment is often more expensive and the intervention needed may be more severe and costly than if the problem had been dealt with earlier, or prevented in the first place.

This was part of the early learning that lead to the design of Catamount Health. The structure now in place acknowledges that the office of the primary care doctor is the kitchen door of health care. Catamount Health is based on understanding that it takes a team approach to provide the support, education, and guidance that will help people lead healthy lives. Personal responsibility can be exercised more easily and sustainably if a patient has partners and advocates in the health care system.

The other big area of learning was in the sphere of chronic care. In Vermont we are spending seventy-five cents of every health care dollar on chronic disease. The problem is that, despite dedicated practitioners, people with chronic disease only get the right care at the right place at the right time about 55 percent of the time. We are paying the bill for chronic disease but we are not spending our money wisely. We need to manage chronic disease better by investing in quality, and the health outcomes and financial outcomes will be much better.

Finally we learned how disconnected and fragmented much of the system was that we rely on for accessing and receiving good care. Investments in information technology are crucial in order for patients and practitioners to share information, conduct education, and increase and sustain communication. The potential for improved treatment and prevention, along with reducing medical errors, is significant and well worth the investment.

The foot in the door to universal health care is the fact that as of October 1, 2007, every Vermonter is entitled to an immunization as a right of citizenship. That is a huge step forward. Vermonters who join Catamount Health will pay premiums based on their ability to pay—no small step. After two years of private sector operation of Catamount Health, the Commission on Health Care Reform will compare that record against the option of having the state

assume the risk and simply contract with a company to administer the plan. The language in the bill states that administrative costs have to be included in the comparison. No longer will the discussion about administrative costs be hypothetical—the numbers will be real.

I believe Catamount Health is a significant first step in transforming our health care environment. Right now we are all taking turns driving a gas-guzzling health care car. There are many drivers of health care, and we all take our turn at the wheel. Some of us use it too much—that is utilization. Hospitals continue to build and expand and compete—that is capacity. Doctors (and insurance companies) dictate how long a person stays in the hospital—prescribing patterns. Prescription drugs do incredible things, but costs are excessive.

Technology is always advancing and providing greater tools to diagnose and treat patients, and with that comes a price tag. The fact is all the drivers are in this gas guzzler and, if we don't get beyond talking about how we are going to pay for gas at the pump when we know it's going to cost more every year, then we really have not done our job. We need to make our health care system more fuel-efficient.

In the House Health Care Committee room, we had a saying tacked to our wall that said "Culture eats strategy for lunch everyday of the week."

What is required is a cultural shift, and it will require bold, continued leadership. Catamount Health is a first step, and as a first step it should be celebrated. By the same token we cannot pretend to have solved the health care problem—we have just begun. Parties will have to give ground and leaders, both political and in the health care field, will have to be willing to take some arrows in the back. Vermonters will have to remain engaged and exercise patience.

As with any public policy development, the public education component is crucial. Vermonters have yet to be given the necessary information regarding our current status in public financing of health care. Many Vermonters understand that our tax dollars pay for our teachers' health care, but they are not aware that we also pay for police, fire fighters, state and local employees, the governor, congressional representatives, supreme court justices, the military, the elderly, the disabled, and those without financial means. When you put it all together, we as a state and a nation publicly finance well over 50 percent of health care. When you add-in nonprofit status for our hospitals, and tax credits for employers who provide health care, we edge-up closer to 60 percent.

The fact that an overwhelming amount of the health care bill already is borne by the public must be part of the discussion as we transform our health care environment. We should not be afraid to have that discussion; in fact we need to have it if we are indeed going to continue to engage in an honest debate. We need to have all the options on the table.

In all of the testimony that came before the House Health Care Committee over the two years that it took to develop Catamount Health—in the committee, in the halls of Montpelier, and in our public engagement process—not one soul said "keep doing it the way you are doing it." We heard that loud and clear.

*John Tracy is a former state representative from Burlington. He was chair of the House Health Care Committee 2005-2006 and co-chair of the legislature's Commission on Health Care Reform. He currently works for Senator Patrick Leahy.*

## Member Perspectives: Looking Back, Looking Ahead

At the beginning of 2007, the members of Coalition 21 were asked to provide their perspectives on the outlook for efforts to continue to transform the health care system in Vermont. Sixteen members responded and offered a variety of views that take us from the collaborative conversations of Coalition 21, through the passage of Catamount Health in 2006, and into the realm of what is still necessary for these efforts to achieve the goals that the legislature, the administration, and indeed Vermonters have laid out for this process.

There are still many different and even contradictory perspectives being voiced. For real progress to be made, two things are critical. First, the divergent interest groups must continue to find forums to talk together and work on common problem-solving in the years to come. Second, it will be the job of all to ensure that the voices of Vermonters—all Vermonters—are not lost in the process, especially as the discussion turns to the administration of Catamount Health and other specific initiatives in finance, technology, and management systems.

## Where VT is Headed in the New Context of Catamount: A Primary Care Perspective

### Hunt Blair, Bi-State Primary Care

One striking element of the reaction to Acts 190 and 191 is that people outside of Vermont find it far more sweeping and significant than many of us here found it (especially those of us who hoped for something even bigger and more sweeping).

However, having had the chance to hear the Massachusetts reform legislation reviewed and explained in many contexts, and to look at some of the emerging national and state proposals, it is hard to dispute that—imperfect though they may be—the Catamount health reforms are easily the most ambitious efforts at systemic reform in the nation.

Key words: Ambitious, Systemic—Aspirational.

As so often noted: *A first step on the road to Big Reform*.

But a significant first step.

Our admirers from beyond our borders are on to something, and we would do well to give ourselves more credit. We have made it clear: Vermont health care reform isn't just about coverage and access, it is about *systemness*. It is about redesigning the care delivery system to improve its quality of care, cost effectiveness, and value. Those things will clearly take time.

Implementation—including further refinements and multiple adjustments and course corrections—will be a work in progress for quite awhile. Nonetheless, the base platform enacted into law, starting with the Coalition 21 principles, provides fertile ground for continued development of meaningful, sustained change.

None of this is going to be particularly easy, or even clear, but Bi-State's health center and clinic members are rising to that challenge. We have created the Vermont Rural Health Alliance to bring primary care practices together to collaborate on and serve as a "test bed" for reform implementation. Recognizing the pivotal role of primary care in a transformed health delivery system, we are partnering with VITL, VPQHC, and the VDH to explore ways in which the theory of systemic reform can be put into practice.

Looking forward in early 2007—working from a place of enacted law instead of amorphous hopes, concepts, and theory—we are an incubator of change, positioned to provide insights to a national debate on systemic reform that will only grow more acute and intense. As Vermonters and as members of Coalition 21, we should be very proud of that. Something bigger than all of us has been set in motion and, unlike all previous runs at health care reform, this time there is no turning back.

## Health Care Reform – Principles and Beyond

### Jim Hester, MVP

The task that lies ahead of us in Vermont is how to realize the vision embodied in the reform principles that were the most significant tangible product of Coalition 21 and are now the preamble of Act 191, the health reform legislation passed by the legislature last spring. Act 191 is an excellent beginning, but it is by no means the end point. The reality is that no one knows how to achieve the transformational changes, both in access to health insurance and in improving the health of Vermonters, that will have to occur to achieve the vision. We know these changes will be hard. They will challenge our skills, fray our patience, and test our trust in one another.

Implementing transformative change in health care requires finding the right leverage points and sequence of interventions to actually move the large-scale health 'system' that touches virtually every resident of the state, accounts for a significant portion of our economy, and is fragmented into a Byzantine network of pieces connected only by the patients they serve. This change will require the active collaboration of all key stakeholders—public and private, providers and patients, employers and insurers. Our challenge is to build true 'systemness' into the prototypical non-system of our time.

Vermont is in a unique position to attempt this. As has been pointed out repeatedly, we enjoy a number of advantages that make us an ideal laboratory for health care reform. First, our scale is manageable, with 600,000 residents, 'only' 60,000 uninsured, and a network of thirteen community-based hospitals that do not compete aggressively for market share. Second, our culture is collaborative, and that spirit is reinforced by a series of organizations—such as Vermont Program for Quality Health Care and formal workgroups like the Blueprint for Health—that provide an ongoing forum for diverse groups of stakeholders to work with each other. Finally, we have already been working on this issue for four years and have accumulated valuable, hard earned experience.

So, although the principles that came from Coalition 21 were a tangible product, they may not turn out to be the most important legacy of that effort. I believe that another major outcome of the many hours that group spent together is the reservoir of good will that gradually built among diverse members who never really expected to find common ground with one another. We did in fact reach consensus on the principles, then went our own ways as the battle raged in the legislature to sort out exactly how Vermont was going to begin the process this time. Although this process used much of the good will we started with, my impression is that it is still there. It is time to call on it as a resource again, because it will be much needed in the next couple of years.

The principles provide a clear North Star that helps establish a common vision of the direction we wish to head. However, we have a small craft heading out into rough waters with storm clouds ahead. We will need a strong crew and a shared commitment to navigate those waters and hold true to our course. Our one hope is to make this journey together, because we have little chance of making it separately.

*Note: As of March 1, 2007, Jim Hester has left MVP to become the director of the legislature's Commission on Health Care Reform.*

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## Coalition 21 and the Nonprofit Sector

### Jane Van Buren

What do Blue Cross and Blue Shield of New Hampshire/Vermont, Vermont State Nurses Association, The Windham Foundation, AARP, The Snelling Center for Government, and the Vermont Business Round Table have in common? They are each independent and private nonprofit organizations serving people, organizations, and businesses in the state of Vermont. They each represent a different point on the continuum of what we call the nonprofit sector.

The critical issue of access to affordable, high quality health care muddies the complex waters already

swirling beneath that nonprofit continuum, and these organizations, along with others, joined to form Coalition 21.

Nonprofit organizations are providers of health care to the public—those without an ability to pay for care, as well as those who are able. They are also employers who struggle with the high cost of proving health insurance to their employees; they are the insurance companies that create health coverage policy; and they are the associations representing hospitals, nurses, doctors, and home health workers. For the first time in Vermont history, Coalition 21 brought together a broad representation of key opinions, individuals who were for the most part leaders of nonprofit organizations. Sitting around the table, we represented our constituents: people with disabilities, older Vermonters, uninsured Vermonters, and employers. We also represented hospitals, clinics, labor, education, home health agencies, health insurance companies, and private medical practices.

It is because of this rich and diverse mix of people and organizations that I remain hopeful about the future of health care and coverage in Vermont. The nonprofit sector is able to straddle and understand many worlds, across multiple perspectives. Many of us have seen first hand in our work the results of under-insurance or lack of access to quality care. Many of us work with people who have chronic mental illness whose lives are dependent on affordable treatment and medication. Or we work with elderly clients who choose between buying groceries or prescriptions.

On one hand, nonprofit workers are skilled and tireless advocates for the people they serve. On the other hand, nonprofit organizations are facing the same challenge as for-profit organizations to cover rising insurance premiums for their employees. In too many cases, the line between the employee and the client fades, and no other sector can be as aware of this as the nonprofit sector is.

It is unrealistic to expect agreement simply because we share a similar tax code; however, the organizations that comprise the nonprofit sector in Vermont can reach general agreement. The membership of the Vermont Alliance of Nonprofit Organizations, for example, embraced the following policy points:

- Make health insurance coverage more affordable for nonprofit employers.
- Improve access to health care for all Vermonters.
- Maintain quality of care for all.
- Increase investment in the direct work of Vermont nonprofit organizations by reducing the cost of unemployment insurance, workers compensation, and other insurances, while retaining focus on the needs of employees.
- Collaborate with other business groups to promote legislation that addresses real cost savings in these systems.

Moving forward, it is crucial to involve the many points on the nonprofit continuum in all health care policy discussions. The large nonprofit hospital and the small 2-employee organization are better served by a bridge than a ravine, and any successful health care reform effort will need both voices.

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## The Key is Collaboration

### Bea Grause, Vermont Association of Hospitals and Health Systems (VAHHS)

Health care reform, even in its most basic form, is complex and laborious. Add in the often disharmonious interests of health insurers, providers, advocates, and legislators, and success becomes elusive at best. So how does a program like Catamount Health come to be? In one word: collaboration.

No one could have predicted what path or shape this legislation took, but one thing is clear—it was a group effort. The collaboration of legislators, the administration, and stakeholders has been and will continue to be one of the most important elements to health care reform. Without communication and cooperation, Catamount Health, the Blueprint for Health, and Health Information Technology would

have fallen apart very early on.

Although these efforts are all very good first steps, implementing these ideas will require more collaboration than ever. As one example, Vermont Information Technology Leaders is working to create a state-wide "electronic" health care system. This work has already taken months, and new laws around respective liabilities and immunities will likely be needed. VITL's efforts impact the progress of others, and any delay will likely hold up the HIT tools slated for physicians as they work to incorporate practice changes aligned with the states' chronic care initiative—the Vermont Blueprint. This could impact physician participation and, as such, slow the Blueprint's progress, which in turn will have implications for related efforts like payment reform.

Key areas of concern about Catamount Health include funding, affordability, timing, and expectations. Although the numbers work on paper, implementing the many moving parts will take time and will no doubt produce missteps and mistakes. As we learn the lessons of implementation, the state and stakeholders will likely identify new issues and barriers to change that may complicate and delay scheduled improvements. To the state's credit, there has been a significant investment in the coordination of health care reform, but keeping the many musicians playing in concert will be no small feat.

Coalition 21 principles clearly helped guide the framework that we now know as Catamount Health. The vision that these principles created, however, is a long way off from where we are today. My hope is that legislators will continue to go back to these principles as they conduct oversight, and also as they do the budget. If they don't, we will undoubtedly lose focus.

Vermont is trying to do what no other state has embraced so comprehensively—fix some of the fundamental flaws in our health delivery system. We all hope these efforts will make health care less expensive. Do we have the resources to fix these flaws, or will demographics and ever-increasing patient demand eclipse any decrease in cost or utilization? Even the best collaboration may not be enough to quickly or sufficiently reduce health care costs. Maybe where we should go from here is to redefine—or better define—what we mean by successful reform.

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## Coalition 21, and Then Some

**Mark R. Neagley, President, Neagley and Chase Construction Company; Chair, Health Care Committee, Vermont Business Roundtable**

One of the joys of living in Vermont is that we are small enough to get to know one another, across the state, as neighbors. When confronting complex issues such as the affordable delivery of quality health care, Vermont has the unique position of being able to bring together an array of knowledgeable stakeholders with multiple perspectives willing to understand one another as neighbors and seek common ground. My participation in Coalition 21 as a representative of the Vermont Business Roundtable was grounded in that belief.

Catamount Health Plan is the offspring of a concerned legislature, Coalition 21, and the efforts of others. It is not a plan that makes everyone happy but is well intended, a step in the right direction, and measured in its impact on the Vermont business community. All of us are tied together economically. It is a simple truth that without a healthy business climate, there are fewer available resources to fund social initiatives.

As a businessperson, I want to know the long-term impact of any spending policy, private or public. My employees count on me to make good decisions, fiscal or otherwise, so their jobs and families are secure, and I expect nothing less from our government officials. We will now see, over the next two years, the impact of Catamount Health Plan—where it works well and where it doesn't—that we may refocus our efforts to fine tune and improve what we initially set out to achieve to the betterment of the lives of all Vermonters.

Vermont faces many challenges ahead as we continue

to work on health care transformation and other issues ripe for reform. We know the collaboration model, such as Coalition 21, works in that in brings to the table a broad spectrum of ideas and solutions. However, those ideas and solutions need to integrate with a few fundamental realities specific to Vermont. Among those realities, perhaps at the top of the list, is the fact that Vermonters are currently taxed to their limit. As neighbors we bear a greater burden for each other than almost every other state in the Union. We cannot risk pushing hard-working, salt of the earth people out of Vermont. It is more rewarding to encourage your neighbors to help through incentives than by adding to an already overloaded tax burden. Similarly we need to recognize that businesses in Vermont face daunting challenges. Our employers pay high rates for insurance, electricity, physical space, taxes, and fuel. At a time when global competition is demanding more from every employer, we have to be careful not to add too much more load to that equation. It is much easier today to relocate, cut costs, and compete where the business environment is welcoming.

Another cold hard reality facing Vermont, which should govern the thinking of any reform group working on the Coalition 21 model, is the reality of our aging population. Not only is the number of Vermonters reaching retirement age rapidly increasing, the number of young people raised in Vermont and staying here to continue the role of the taxpaying workforce is rapidly decreasing. For years employers have lured people to Vermont to capture a way of life and raise a family in a special place. As neighbors we understand that living here is worth a premium. The problem today is all the other premiums confronting families are going up and out of sight, taking future leaders and entrepreneurs out of state with them.

The best of Coalition 21 was the encouragement of thoughtful leadership and collaboration. When 'agendas' are left at the door, the likelihood for finding common ground blossoms. What our health care conversations revealed to me was that not all problems could be solved efficiently on a state level. What is equally true is that the very least that will happen is an insightful declaration of principles around which intelligent solutions can be created.

As an employer I would support a similar process for moving Vermont's business culture into the next generation. It's time to be excited about all that Vermont has to offer, and to match our intentions with predictability for new employers. If we as neighbors, state officials, regulators, and business leaders can move away from our differences and stand together on unified principles, we will be "making Vermont the best place to do business, be educated, and live life." It's not important that we finish the process tomorrow, it is important that we start working together today.

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## VBSR Perspective on Coalition 21

### Leslie Nulty, Vermont Businesses for Social Responsibility, Public Policy Committee

VBSR was an enthusiastic participant and supporter of Coalition 21, and would continue to be if it were to be resurrected in some manner. At the time the Coalition was constituted, substantive reform of the health care system had become one of the most important, if not the most important, public policy initiatives pursued by VBSR. We had heard, and we continue to hear, that the current health care financing system imposes substantial burdens on our members. This burden is felt especially keenly because they share a commitment to providing 'livable jobs' to their employees, including a comprehensive compensation package, to the greatest extent consistent with their own financial sustainability.

The continuing double-digit increases in health care insurance premiums and out-of-pocket costs of recent years, combined with the pressure of these same forces on state and local government financing, had become, in our view, completely unsustainable. In addition, the degree of pressure threatened many of our small business members' ability to honor their commitment to the health care component of livable jobs. A further concern was the competitive disadvantage to businesses like ours, who do offer employee health coverage, vis-à-vis competitors who do not. Thus, VBSR has been particularly concerned with the disparate distribution of the cost of maintaining our health care infrastructure, and the need to eliminate the 'free rider' problem, both from

users of the system and from those who pay into the system.

In joining Coalition 21, VBSR recognized that there is a diversity of stakeholders in our health care system, and that all of them had to be able to contribute to advancing system reform if any reform at all was to be achieved. We were delighted when this diverse coalition was able to develop a set of fundamental principles that all agreed with and that were also consistent with our principles. Now we can see that we needed to do further work to assure that we all attached reasonably similar meanings to those principles.

At the same time, VBSR also recognized that any reorganization—whether of the health care financing system, the delivery system, or the range of health care services provided—would likely entail some sacrifices from various parties. In retrospect, it is not clear to us that other Coalition 21 members, who were 'at risk' with respect to advantages they may enjoy in the current system, shared this view and/or entered into the process with a willingness to make some kind of sacrifice. This question was never explicitly discussed in the coalition process and perhaps needs to be discussed now.

Throughout the coalition's work, VBSR remained cautiously optimistic about the effort. It was extremely disappointing, then, to have the coalition's efforts fall apart as health care reform became a hot political issue in the 2005 state legislative session. The participants were not able to operate on two levels: the first being their immediate need to respond to the legislature's initiatives, and the second being their need to work toward a consensus on acceptable measures toward comprehensive reform. With respect to VBSR, while we were enthusiastic supporters of the 2005 bill, we also recognized that as a practical matter, effective transitional mechanisms had to be explored before the kind of sweeping reform embodied in the legislation could be affected.

Unfortunately key members of the coalition, in particular the other business groups and MVP, decided to withdraw from the coalition process. This occurred just as the coalition subcommittees—which had been formed recently—were just biting into some real work. For example, the Financing Sub-Committee on which VBSR participated had been working up a credible structure of regional health centers through which financing could flow more effectively, and with better discipline, than is now the case. The sub-committee had been about to grapple with ways to contain some of the key cost drivers in the current system. But this work was halted by the defections from the coalition. That action effectively terminated the coalition's work and influence.

If there were some way to resurrect that activity, a great contribution would be made to the future of reform efforts in the state. To VBSR, one of the most important tasks remaining is to design system change that will drive out unnecessary costs while protecting the quality, and increasing the universality, of health care delivery and financing. This effort is still missing from legislation that has since been passed, and so the need has not gone away.

To summarize, these are some of the questions yet to be tackled in the search for effective health care system reform:

1. Can we reach an acceptable consensus on what costs can be eliminated from the current system without unduly compromising the coalition principles, and what are some mechanisms for achieving that?
2. When/if "savings" are achieved, who will/ should capture them?
3. Do we need better/different regulation of health care insurance premiums and carriers?
4. Should paying for the health care system continue to be voluntary? If not, what measures are needed to bring all residents into participation in financing health care?
5. What incentives/pressures can be brought to bear on health care providers to reduce unnecessary care and to assure "best practices?"
6. Is it possible to reconstitute Coalition 21 under improved "rules of engagement," and with a commitment to accept and encourage more active facilitation, to move the group toward agreement on some set of fundamental reform measures?

## Vermont Chamber of Commerce Perspectives

### Duane Marsh, President

The Vermont Chamber believes health care and health care insurance should be affordable, and thus more accessible, without sacrificing the quality of service and freedom of choice that Vermonters have come to expect. Government should lead the way toward meaningful and long-term accountability that encourages cooperation between the consumer, the provider, the insurance carrier, and the market.

Real and long-lasting reform will take place when our health care system rests in the hands of the consumer and the provider to seek insurance products, options, and cost structures that meet the demands and needs of end users.

Vermont has concentrated on maintaining a high-quality health care system with a goal of complete access to health care by Vermont citizens. Contributing factors to the high cost of this system include: greater use of technology, increased demand and utilization of health care services, technologically superior treatments, and prescription drugs; law suits against doctors and hospitals; the cost shift caused by government-funded health care programs; hospital budgets, including the need for and value of highly qualified health care providers; underpricing by insurance carriers; legislative mandates; and administrative rules. The challenge is to strive for reforms that first and foremost do no harm, but that address the fundamental drivers of rising costs, stimulate healthy choices, and emphasize preventative care.

Vermont's health care policy should recognize that competition among health plans and providers is an important part of reducing health care costs. A new plan should be based on components that: focus on patients and give decision making responsibility to patients and their doctors; begin to reduce costs; and are financially sustainable with public and private dollars. The Vermont Chamber maintains the following positions:

- Health care proposals that do not unfairly target businesses to fund or subsidize these initiatives should be encouraged.
- Eliminate cost-shifting caused by inadequate government reimbursement to health care providers for Medicare and Medicaid by focusing on prioritized spending rather than new revenue.
- Increase access and treatment options, control costs, and improve quality through open and competitive market-based measures that encourage a strategy where demand, supply, and choice find equilibrium, such as increased flexibility in community-rating-based underwriting.
- Provide consumers and payers accessible, useful information to compare provider performance in order to take more control and responsibility for their health and the attainment of proper medical care, and to bring about accountability from providers for quality and cost of care.
- Oppose a single-payer health care system, and instead support policies that enhance the health care market, allowing continued employer participation.
- Efficiency and performance standards for government purchases of health care services should be encouraged.
- Reduce premiums through initiatives that spread the cost of health care over a larger segment of the population. We support initiatives that decrease the number of uninsured Vermonters, provide premium discounts for low and middle income Vermonters, and reduce the cost for small businesses to start providing insurance for their employees.
- Recognize the need for tort reform to minimize defensive medical practices and to discourage frivolous lawsuits.
- Encourage thoughtful and responsible utilization of medical services, encouraged through cost-sharing techniques such as co-payments, premium contributions, deductibles, and health care savings accounts.
- Provide the self-employed with the same health insurance tax equity as other businesses.
- Reduce the cost impacts of mandates and regulations.
- Encourage personal responsibility in health care decisions.

## Health Care Reform: Moving Forward

### Richard Davis RN, Executive Director Vermont Citizens Campaign for Health

Vermont passed a health care reform bill, Catamount Health, to help insure the uninsured. No bill is perfect, and this bill is flawed in many major respects. But, it has the potential to open the door to more meaningful reform, and we must seize the opportunity.

Catamount gives us a chance to show a direct connection between property taxes and health insurance costs. If we lower the cost of health insurance, we all save money. If we lower the cost of health insurance for municipalities and school districts, we will see our property taxes go down. Here's how it could work:

Catamount only allows uninsured people (someone who has been uninsured for a year) to buy in, either at full cost or at a subsidized rate, depending on income. Current projections are $420-a-month per person for full cost, and $135-a-month for a person making $29,400 a year, with lower rates for lower incomes. There are other provisions for subsidizing low-income workers who have insurance through their employers.

Recent news stories have indicated that the Vermont League of Cities and Towns (VLCT) have been facing a 36 percent increase in their health insurance rates. VLCT is an organization that represents Vermont municipalities and has been providing access to group insurance for municipal workers. They have lowered that estimated increase to 12 percent recently by switching insurance companies, but the added cost will still have an effect on town budgets and, therefore, tax rates.

Why not have the new legislature create a provision that would allow VLCT to buy into Catamount? If the Catamount rates are lower than the proposed new VLCT rates, that would have an immediate effect on property taxes.

If we really want to get radical, we could think about having teachers' contract negotiations consider a Catamount buy-in when the contracts come up for renewal. If the legislature makes that possible, then we will see a dramatic drop in property taxes. Everyone wins.

An even more radical idea would have every Vermonter able to buy into Catamount based on income. Could the state afford it? Would it be too much of a burden for a new program?

There are many who strongly believe that Catamount just won't work in the real world. The proposed funding mechanisms seem too tentative, and the new administrative complexity that has been created flies in the face of most ideas of sensible health care reform. If we push for maximum enrollment, and we get as many people as possible to sign up for Catamount, and it succeeds, that's O.K.

But if Catamount proves to be a failure because of its shortcomings, while Vermonters line up with the hope of affordable health care, then we will have to go back to the drawing board and find a sensible, sustainable funding mechanism. And we will have to create the administrative simplification we know we need. Now is the time for all of us, especially the non-politicians, to tell their elected officials that they understand the link between property tax rates and health insurance, and that there are solutions to this problem that make sense. If we simply sit back and let Catamount play out as is, we all lose. We must push for changes, and we must be prepared for the success or failure of Catamount.

We are only a short distance from the starting point of health care reform. There is still a lot of work to be done.

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## Perspectives of the Vermont Council of Developmental and Mental Health Services

### Julie Tessler, Executive Director

The principles that were developed through the Coalition 21 process are essential ingredients to ensure the future of a coordinated-care system for all Vermonters. Mental health services are part of

that coordinated model, and as new systems are implemented and others designed, integration of these services needs to continue.

With adequate funding and support, community mental health centers are eager to replicate proven coordinated-care models and provide the comprehensive care their patients need to stay alive and fully well. Therefore, we need to ensure a strong dialogue about the resources that all behavioral healthcare agencies need to be certain that people with serious mental illness and addiction disorders are adequately screened and triaged for physical illnesses. Most of the national attention has focused on primary-care sites. Acknowledging that mental health is integral to overall health, the Health Resources and Services Administration (HRSA) has underwritten mental health expansion initiatives in community health centers. As a result, the percentage of community health centers providing mental health services has grown from 53.8 percent in 1999 to 72.2 percent in 2004, representing 139.8 percent growth in the number of persons served, and 75.9 percent growth in mental health visits, according to the National Council of Community Behavioral Health.

Sadly, general health care for people with serious psychiatric illnesses and addiction disorders being served in community-based behavioral health organizations has had far less attention and no additional funding support. Funding will enable organizations to pay skilled staff, to allocate adequate space, and to buy basic equipment. Just as screening and evaluation for behavioral health disorders is appropriate in primary-care settings, screening and evaluation for general health problems should be available to individuals in behavioral health settings.

The fragmented health care system is difficult to navigate, especially for those with mental illness, who can be cognitively impaired. They are often too debilitated to seek care from multiple providers. To ensure that they have access to proper care, community mental health organizations must be clearly defined as their allowable medical homes. This will help to prioritize continuity of care by allowing such persons to continue to seek care from providers they know and trust. Persons with mental illness need providers knowledgeable about their behavioral, medical, and social needs. Often, the medical and social needs are directly related to symptoms of the mental illness and are specific to the individual. Community mental health providers are best suited to understand and meet this spectrum of needs.

Given concerns about rising health care costs, Vermont, like other states, must find ways to make the mental health system more efficient. Vermont has an excellent opportunity to lay the foundation for coordinated care. By acknowledging community mental health organizations as medical homes, and by encouraging them to create and sustain relationships with primary care and other specialty providers, the healthcare system will be able to better serve persons with mental illness.

System transformation must include giving individuals with serious mental illnesses a chance for a full and long life. The federal government (specifically, the Substance Abuse and Mental Health Services Administration and HRSA) needs to be encouraged to set standards to ensure that funding is available for every provider of public behavioral health services to assess the health status of all individuals receiving antipsychotic medications, and that specific protocols are in place for medically monitoring such individuals. An integral part of services should be to ensure that each person is connected to primary care, that there are specific mechanisms between behavioral health and primary care providers for coordination of services, and that the option exists to bring primary care into behavioral health settings. If we want to build a better future for adults and children with mental illnesses and addiction disorders, we need to start by saving lives.

**The Vermont Medical Homes Project**

In 2002, Vermont received a grant from the Center for Health Care Strategies, supplemented with state funds, for a two-year pilot project designed to improve the physical health needs of adults with serious and persistent mental illness. In three counties, "Care Partner" nurses were placed in community mental health centers, where they performed health assessments, made connections with primary care providers, and served as members of the community mental health centers' treatment teams. After much

consideration, the community mental health centers and the nurses decided to begin the pilot by focusing primarily on consumers who were diagnosed with Type II diabetes. The nurses helped consumers implement nutrition and exercise programs as part of their recovery self-management plans.

Although the pilot ended in January 2005, the results are encouraging:

- Prior to the implementation of the pilot, the 80 participants averaged 54 inpatient hospital days related to diabetes.
- In the twelve months following the pilot, the same group experienced no hospital days.[1] At the Howard Mental Health/Community Health Center of Burlington site, inpatient days for complications related to diabetes dropped off drastically.
- Planned-care visits for diabetic consumers more than tripled, meaning consumers were keeping regular appointments designed to help them better control their diabetes.

Innovative, coordinated care programs can and will ensure better care at a lower cost for all Vermonters.

[1] Commentary supplied in part by the National Council for Community Behavioral Healthcare. www.nccbh.org.

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## Tackling the Cost Side of Health Care

### Deborah Richter, MD, Vermont Health Care for All

Vermont Health Care for All continues to take the view that all serious problems in Vermont health care can be traced to the unrestrained rise in costs. And that all unrestrained rises in costs can be traced to what's missing in Vermont's health care: a system.

The health care reforms passed by the 2006 legislature made no acknowledgement of this reality. The problems that now plague Vermont health care will continue to plague it and, a case can be made, may well be magnified by these very reforms. Costs will rise faster than promised cost reductions can happen.

Promises by the administration and the legislature have had an illusory effect: They have bought breathing space for two, possibly three or four years, during which it can be claimed reforms are being implemented and the best advice is to wait and see.

Waiting may be a good political choice but a very bad practical one. Cost problems—and their widespread effects—are not going to sit on the sidelines and wait for these timid reforms to work, if work they do. There are penetrating reasons for doubting their efficacy, both on paper and in the real world of health care.

The 2006 reforms are based on a crucial set of misunderstandings. One is that reforms can be implemented successfully without a fully-integrated health care system. Vermont's is not fully integrated, and that spells trouble for these reforms.

A second is the firmly held belief that the point of departure for cost savings of any kind is utilization, as measured in discrete units at the origin of treatment. Vermont Health Care for All—and others—argue that fixed costs of services, not utilization, are the drivers of overall cost.

Using these two assumptions as a starting point means the reforms are on life support before they are implemented. Catamount will insure a few more people, it is true—a very small percentage of the population—but it will not affect costs, other than raising them for the state. In anticipation, insurance costs already have soared.

Blueprint for Health's measures (chronic-care management) have not worked anywhere except in very narrow, *system-like* circumstances. Vermont does not have the system elements required. It could have them, but they are very costly, so to achieve them will mean a big bump in costs to the state, and possibly the medical community.

So in our view, costs—the driver of all reforms—can be counted on to pursue their steep rise. Any promises of savings are so far down the road that, by the time we get there, it won't make any difference to what is a developing catastrophe. Why? Because the reforms are going to impose more bureaucracy, more

costs, more paperwork, more overhead on a medical community already demoralized by conditions over which they have no control.

The 2006 reforms no doubt were a political achievement. Will they make a practical difference? Only time will tell. Our position is, we don't think they will; we don't think we have the luxury of waiting three, four, or more years to find out; and that, aside from all else, the real harm of the 2006 reforms is, in all likelihood, they will delay any serious legislative attention to reforms that could fit the real world of health care.

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## Looking Ahead

### Trinka Kerr, State Health Care Ombudsman, The Vermont Low Income Advocacy Council

Like other hard-working Americans, many Vermonters are facing greater and greater economic insecurity. And increased economic risk is not just a problem for the poor and uneducated; it is a trend across all income levels. Health care insecurity is just one piece of a growing national anxiety, but it is a major piece. Many families are just one medical catastrophe away from financial hell. Jobs are increasingly insecure, and employer-sponsored health insurance is on a fast track going down. America's hodgepodge of economic protection, a mix of government and private-enterprise initiatives, is unraveling. Yale professor Jacob Hacker calls this the Great Risk Shift, and argues it is the result of a concerted drive for greater "personal responsibility". Nowadays, financial risk is less often spread across a large population. Emphasis is no longer on a communal spirit of "we're all in this together." Instead, individuals and families are more often required to "go it alone," with disastrous consequences if things go awry.

Like some other states, Vermont has stepped into this fray and creatively tried to fix some of the holes in the health insurance safety net. As a result, its health care financing system is in a major state of flux right now. Many of the State's recent initiatives, including the Global Commitment for Health[1], VPharm[2], Choices for Care[3], the Catamount Health Assistance Program[4], and the premium assistance programs[5] for either Employer Sponsored Insurance (ESI)[6] or Catamount, are big gambles with public dollars that could have positive impacts on the lives of many low income Vermonters. Or not. The complexities and risks inherent in the new programs render the future uncertain.

The State is putting a huge amount of effort into these various programs. If they all come to full fruition, it could mean the state's citizens with incomes below 300 percent of the Federal Poverty Level could have significantly better health care and greater peace of mind. If the various programs dovetail smoothly, if the income fluctuations that frequently bedevil lower-income workers don't cause disruptions in coverage, if the government and insurance company bureaucracies function in a beneficiary-friendly manner, and if consumers understand their options and are able to pay what is expected of them, more people will have coverage. But these are a lot of 'ifs.'

The new continuum of coverage has many moving parts. How many people will take advantage of the new opportunities in the face of the complexities is uncertain. ESI programs in other states have had very low enrollments. Recent projections for Catamount enrollment in fiscal year 2008 were reduced from 4800 to 2600, out of 61,000 uninsured people. The forecast for 2010 was dropped from 14,500 to 7,000. How expensive will Catamount be, and will many people think it is truly affordable?

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[1] The Global Commitment to Health is Vermont's new five year Medicaid waiver, which caps the amount of federal dollars available in return for greater flexibility.

[2] VPharm is Vermont's State Pharmacy Assistance Program, which "wraps" Medicare Part D prescription drug coverage.

[3] Choices for Care is a Medicaid program that allows Vermonters who need nursing-home-level care to stay at home and receive home-based services.

[4] Catamount Health is a hybrid of government and commercial insurance, with private plans offering this new individual insurance product to uninsured Vermonters beginning on October 1, 2007.

[5] Premium assistance will be provided to subsidize premiums to enable lower income individuals to buy either ESI, if it's available, or Catamount insurance.

[6] Individuals who want to be on either the State's VHAP program or Catamount, but can get insurance through their employer, must enroll in Employer Sponsored Insurance (ESI).

And will the ESI premium assistance program catch on in Vermont? Will these programs make a dent in the number of uninsured people?

If the numbers are too low, we may have to turn to pressuring the federal government to take some responsibility. We already may be heading toward the day when employers no longer offer health insurance at all. The slow decoupling of health insurance from employment, and the growing number of uninsured people who cannot afford or are not eligible for even the supposedly affordable Catamount, could cause Vermonters to insist on a national conversation—not just a state conversation—about health care insecurity. It could tip us toward demanding expansion and improvement of government programs like Medicare, which spread the risk across a very large population. It could start reversing the Great Risk Shift, moving the risk away from individual workers and families, and back on to the larger community as a whole. So workers and families don't feel that they must go it alone.

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## Lack of Attention on Pending Physician Shortage Will Result in Decreased Access to Care

### Paul Harrington, Executive Vice President Vermont Medical Society

As the legislature and state government focus on implementing the details of Act 191, there seems to be a lack of attention to whether or not Vermonters will have adequate access to physicians, even with the new insurance coverage options.

Vermont is beginning to see the effects of a serious physician shortage. Residents are having a more difficult time finding a doctor when one is needed, and when they do locate one who will see them, the wait for an appointment may be lengthy.

This decrease in access to primary care in Vermont has been well documented in physician surveys conducted by the Department of Health. The number of primary care physicians accepting new patients declined from 92 percent in 1996 to 81 percent in 2004. The drop in physicians accepting new Medicaid patients was even sharper—from 86 percent in 1996 to only 70 percent in 2004. The surveys show a similar decline in access to specialty care.

In addition, the most recent survey found a statewide shortage of primary care physicians, with only four out of fourteen counties reporting an adequate supply. All the other counties were experiencing serious or moderate shortages.

It's not difficult to find the causes. Physicians leave medical school with an average debt of $150,000. Medicaid and Medicare pay physicians less than the cost of providing care. Medical malpractice insurance premiums have increased significantly. These factors have combined to put physician practices under tremendous financial stress. Fewer medical school graduates are going into primary care, due to the lower pay and difficult working conditions.

Vermont has one of the oldest populations, on average, in the United States—and it is projected to continue to age more rapidly than other states. Older adults are more likely to suffer from chronic illnesses with a corresponding need for increased health care services. The availability of primary care physicians will be key to the success of the Governor's Chronic Care Initiative. Even if Vermont had an adequate supply of primary care physicians today, it would not be adequate to meet the needs of an aging population in the future.

In his recent budget address, Gov. Jim Douglas proposed increasing the Medicaid budget by $7.3 million to raise payments to hospitals and doctors. While this is a step in the right direction, a recent study indicated that the Medicaid underpayment for just hospitals is almost $90 million, so much remains to be done to address the problem.

To ensure that Vermont's supply of primary care physicians is adequate to meet our current and future needs, a number of steps need to be taken. These include:

- evaluating the current supply of physicians in Vermont and projecting future needs;

- identifying how demographic factors impact the physician workforce in Vermont, and affect the need for physicians of various specialties now and in the future;
- evaluating how demographic factors and health status, including chronic conditions, impact the patient population in Vermont;
- exploring increased loan repayment funding as a means to assist in recruitment and retention of physicians in Vermont;
- examining the need for increased Medicaid payment and medical malpractice reform as a means to support the financial viability of physician practices; and
- supporting graduates of the University of Vermont College of Medicine to practice in Vermont.

The stresses that face primary care physicians in Vermont are severe and they stem from longstanding problems. Unless there is a deliberative process developed under the leadership of state government to better understand the fragility of our state's primary care infrastructure, and to adopt additional policies to encourage the recruitment and retention of primary care physicians, Vermonters will have greater difficulty accessing the primary health care services they will increasingly need.

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## Keeping Principles in Mind as we Move Ahead

### Mark Hage, Vermont NEA

Whenever I ponder the next steps in health care reform, I come inexorably to the conclusion that Vermont's state government must provide bold leadership and pass legislation that makes health care accessible and affordable to all Vermonters.

Recently, after taking part in a spirited discussion about the new Catamount Health Plan and other reform measures passed in 2006, a school board member said to me, "You know, I don't like what is happening at the bargaining table around health insurance. But rising costs are killing all of us. *Something more has to be done*."

I hear such sentiments frequently from working Vermonters who are fortunate enough to be insured. These folks, like the uninsured, are equally deserving of health care relief and security, and they expect the legislature and governor to honor their pledge to build on the Health Care Affordability Act of 2006 to provide them with access to affordable, comprehensive coverage.

On this last point, bear in mind that the legislature's efforts during the last biennium were informed not only by the plight of the uninsured and rising costs, but by the realization that Vermonters *with insurance* are concerned about the costs of their health coverage in the future. An AARP Vermont survey in 2005 showed that 75 percent of Vermonters are worried about having to pay more for their health care in the years to come.

As a union advocate who has been on the picket line four times since May, 2005, I can attest to the high level of nervousness among educators and school boards about the cost of health insurance. I also know that such anxiety is not confined to the public sector—it is widespread in the private sector, as well. Unfortunately, the reform legislation of 2006 was not expansive enough to give these people confidence that their health care costs will be dropping soon, or that their access to care in the years ahead will be more secure.

According to a report to the legislature by health care economist Kenneth Thorpe, less than 55 percent of Vermont's businesses offer health care benefits to their employees. The 2006 reform legislation, despite its achievements, is unlikely to slow—much less stop—the erosion in the number of employers offering health benefits, particularly small business owners. This means, of course, increased pressure on workers and their families to absorb more costs of their health coverage through high-deductible plans and other cost-shifting measures, with the added prospect of less extensive benefit coverage as employers look to shave costs further. None of this is good news for Vermont's health care system, its economy, or the welfare of its people.

The 2006 reform legislation, as both legislative leaders and Governor Douglas stressed, was a *first step* in providing affordable health care coverage to all Vermonters. The steps to come will be even more daunting to conceptualize and achieve, because they must resolve fundamental issues still facing our health care system: rational cost management, financial sustainability, systemic quality improvement, and universal access.

As the next stage of health care reform takes shape, our government's deliberations should be informed by the following commitments, study and directions that emerged from the reform efforts of the past two years:

First, *every Vermonter* should be guaranteed access to affordable, high-quality care, from birth to death, as a matter of public policy.

Second, health care coverage must be *comprehensive* in scope and offer, minimally, the range of services found in the Catamount Health Plan—primary, preventive and acute episodic care; hospitalization and immunizations; drug coverage and substance abuse treatment; mental health therapy; and chronic care management.

Third, *everyone must contribute* to the cost of health care, and that contribution should be fair and based on ability to pay. Further, the right of Vermonters to *choose their own doctor* must be protected.

Fourth, *publicly financed health care programs*—Medicaid, VHAP, Dr. Dynasaur, and soon, Catamount—are vitally important to the health and economic security of a large segment of Vermont's population. Until a more equitable health care system and ways to finance it are devised, the state must expand enrollment in these programs and safeguard their funding.

Fifth, soaring insurance premiums and health care costs, cost shifting, and administrative inefficiencies *compromise the quality and fiscal security* of our health care system and its providers, as well as the health of our people. These must be brought under control.

Sixth, the *funding for and budgeting of health care* must be rational, predictable, and sustainable. Seventh, the *quality and safety of health care* must continue to improve, consistent with the precepts of continuous innovation in medical practices, technology, electronic recordkeeping and data collection. More needs to be done to accent the importance of primary and preventive care as the foundation of individual and social wellness, and to overcome the current (and very costly) fragmentation and overspecialization in health care.

Regardless of how one feels about the reform legislation of 2006 and the political realities that engendered and qualified it, two things are clear. Health care reform remains the most important domestic issue of our time. Additionally, the patchwork of funding sources that made Vermont's 2006 reforms feasible—combined with the continuing cost crisis affecting employers, employees, and Medicaid—will compel state government to address, soon and with greater urgency, two fundamental questions:

1. How can our health care system be rationally budgeted and paid for to keep costs manageable, ensure adequate funding and staffing, and advance quality innovations?

2. And, as a corollary, is the connection between health insurance and employment the optimal way to provide affordable access to health care?

This line of discourse will not be welcomed by all—in fact, it will be resisted by powerful interests across the political and economic spectrum vested in the status quo. But it is the right discussion to be having, and the sooner we start, the better.

Vermonters are a tough lot and can handle an honest, intellectually rigorous debate between competing claims on how best to finance and regulate the health care system so that everyone has access to it, and so that the care it offers is affordable and of the highest quality. Not to engage this debate now, at all levels of civic life—in particular, among organized labor and employers, small and large—would betray the expectations of workers and business owners who did not benefit from last year's reform legislation, and

who took the governor and legislative leaders at their word when they asserted that Catamount Health and other measures were an important first step.

Looking to the future, then, reforms that build successfully on the lessons and achievements of 2005 and 2006 must lead, ultimately, to the design and implementation of sound budgets, and to a publicly accountable budgetary and regulatory process for Vermont's health care system. This will entail, among other improvements, sustainable funding mechanisms that spread the cost of the system more fairly across the population, eliminate the pervasive and pernicious effects of cost shifting, and guarantee the fiscal security of our hospitals, doctors, nurses, and other health care providers.

I'm under no illusions about the difficult road ahead. As I noted, the problems that must be grappled with will elicit great passion and opposition. That's fine—and inescapable. What is not fine is to do nothing, or to tinker indefinitely around the edges of our endangered health care system.

The structural recommendations I discussed will require time, analysis, and debate, but that does not mean we have to stand still. Health care reform may be a transitional process, but it must also be one that addresses pressing human needs. Clearly, employers and workers *with health insurance,* especially those who make up the small business market, are being buried alive by rising premiums, out-of-pocket costs, and the threat of declining coverage. Their plight can not be ignored.

I recommend that the governor and legislature come to an agreement this biennium on new or expanded funding options that make it possible for Vermont businesses to afford to purchase coverage for their employees under Catamount Health. Moreover, the same kind of relief should be offered to middle-class Vermonters in the non-group market.

These measures, in and of themselves, won't end the health care affordability crisis. But they will help a lot of working Vermonters, strengthen the ability of small businesses to prosper, and send a message that health care reform is moving forward in the Green Mountain State.

## Creative Partnerships Remain the Foundation for Health Care Reform

### Peggy Sharpe, Vermont State Nurses Association, Inc.

The formation of Coalition 21 was an important and forward thinking step in moving the health care reform discussion in Vermont to a deeper level. All the members were acutely aware of the need for health care reform, and were in agreement that the current system was inefficient, often ineffective, and not sustainable. This health care dilemma affected each one of us personally and professionally. It is driving both our state and national economies. The desire to critically evaluate and examine new options was the key reality we shared. Our individual perceptions of the major problems and possible solutions were as varied as the membership.

Having a group of Vermont citizens who represented a very large and diverse number of stakeholders allowed for a rich exchange of information, ideas, and points of view. Although these ideas were often in conflict and potentially polarizing, the commitment of the individuals on the Coalition allowed difficult discussions and hard work to take place. Without strong leadership and a common purpose, this could never have happened. The environment that was created supported the sharing of strong opinions and respectful disagreement, so a rich exchange took place. This provided an incredible opportunity for each member to delve much deeper into all the layers and complexities of our health care system, and to learn at a much deeper level than any one of our own perspectives and areas of expertise could have afforded us. Being willing to listen and be open to viewpoints on extremely challenging questions related to health care provided an environment for important relations to be formed that will continue to promote collaboration in multiple settings in the future.

After a grueling process, the Coalition was successful in identifying principles to guide health care reform in Vermont. These principles were adopted by the Legislative Health Care Committee and were utilized throughout the 2005 and 2006 session to assist in

guiding the work of the committee as it developed legislation. In 2006 the legislature passed the Health Care Affordability Act that created the Catamount Health Plan. This plan was a result of much hard work and a great deal of compromise. The main goal of Catamount is to provide uninsured Vermonters access to affordable and comprehensive health care.

As our organization looks forward, it is clear that if real reform and cost containment is going to happen, a major shift in focus must take place from a hospital-procedure-based medical model to a community-based preventative model. This will require a shift in resources and mind set. Individual citizens must be involved in the discussion.

Collaboration from all sectors will be paramount in making this change.

Technology must be used in a more positive and preventative way in the community, in people's homes, and in schools for assessment of individual and group needs, as well as for diagnostic purposes. Nurses should continue to move forward with more independent practices to provide models of care that address community health needs, and that provide more holistic care, blending the best of the "East" and "West" approaches. Strong lobbying and public awareness must take place for reimbursement for alternative care delivery models and alternative therapies.

Evidenced base practice and outcome-driven services will need to be implemented and directly linked to funding. The American Nurses Association (www.ana.org) and the Agency for Healthcare Research and Policy (http://www.ahrq.gov/clinic/epcix.htm) have been promoting the principle that all stakeholders should have the best available evidence on which to make decisions about health care items and services. Taking advantage of the work already done in this area will streamline this process.

More emphasis on partnering with schools, communities, and businesses will be essential as we strive to create healthier populations and take care of the needs of the aging population. Expansion of chronic care management with nurse care managers will need to occur, as nurses are best educated for the role of coordination and collaboration that is needed. This expertise is essential for achieving good outcomes, as involvement of many disciplines is required, and the patients/clients must be recognized and "in charge" of their personal goals for health and wellness. Individuals should have access to their personal health/wellness records at all times.

Engagement of consumers in a meaningful dialogue about wellness is essential. To be relevant such a dialogue should focus on issues of health that begin from before birth and extend all the way to end of life decisions.

In addition, setting a lofty goal of having all Vermonters complete Advanced Directives will assist individuals, families, and health care providers in implementing appropriate and compassionate end-of-life care.

Forging creative partnerships to promote wellness in all aspects of our communities will be a giant step forward to creating healthier lives for all of us.

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## The Future Role of Business in Vermont's Health Care Debate

### Otto Engelberth, CEO, Engelberth Construction

The following are my list of possible health care issues that business groups need to grapple with, given the current state of efforts to reform health care in Vermont.

**What is the proper role for the "free market" in the health care system?**

We could look at the apparent conflict in our societal values related to health care. On one hand, we are committed to a system that is based on a market-driven model, while on the other hand, we feel strongly that no one should be denied health care.

On one hand, we want to control health care infrastructure using the CON process, and on the other hand we want the system to respond to

market conditions. To what degree does the payment structure determine what health care services and products are advertised and sold?

On one hand, we want a patient-centered system where individuals have a hand in making the decisions about their health care, while on the other hand, we want to limit decisions to those that are economical and effective.

**What is the nature of the "social contract" that defines publicly-funded health care?**

With nearly 50 percent of Vermonters receiving publicly-funded health care, and that number growing, I believe that we need to examine and define the expectations and limitations of the social contract relating to health care. Questions that I believe need to be addressed are:

- Whose health care is paid for by public funds, and at what level? What is the logic behind these practices?
- Where do the funds come from, who pays, how much, and when?
- Are there limits to an individual's total health care expenditures?
- Assuming that there will always be shortfalls, are there priorities on how the pooled funds will be used? If so, on what basis are those priorities established?
- What are the responsibilities of those who are cared for under this social contract? What are the recipient's lifestyle requirements? What incentive structures are the recipients operating under?

**What real effect does the method of health care funding, and it's aggregate cost, have on Vermont's economy?**

As we move into a time when health insurance may not be a part of the employer/employee relationship, it is my view that someone needs to take an honest look at how this change will impact our economy. The expertise of the business community, if focused on this question, could have a dramatic impact on how the issue of health care funding evolves, and we just may learn something along the way.

Among the questions that could be addressed are:

- What effect would this have on the employer/employee relationship?
- Would this change the mix of full, seasonal, and part-time employees?
- What impact would this have on the formation of new businesses?
- What effect would this have on the migration of employees into and out of Vermont?
- What impact would this have on when and where people choose to retire?
- Would this remove the issue of defining the employee's family from the employer/employee relationship?
- Would this impact single-person businesses to be formed in Vermont.
- Would this encourage the migration of health-care-needy people into or out of Vermont?
- How would this impact workman's compensation costs?
- How much would this reduce employers' administrative costs?
- How would this impact employees' total compensation?
- How would this impact relations with organized labor?
- How would this impact an established company's decision to move to Vermont?
- How would this impact public sector costs?

**What should be the goal in lowering health care cost?**

The most visible symptom of the health care problem is that health care, as it is currently delivered and paid for, is no longer affordable for lower income Vermonters. And this affordability problem will grow because the cost of health care is growing at an unsustainable rate.

It seems to me that any reform proposal worth its salt must, at a minimum, deal with the unsustainable inflation in aggregate health care costs in order to be viable over the long term.

In addition, I believe that health care reform must work to bring our health care costs more in line with

those of the other industrialized Western nations such as Germany, Sweden, Denmark, Switzerland, Australia, and Canada.

To achieve this goal, we would need to reduce our total health care costs by 35 percent, resulting in a reduction of our average annual per-person health care costs from $5,100 to $3,300, and reducing Vermonters' total health care expenditures from $3,200,000,000 to $2,080,000,000. This works out to an annual per-person reduction of $1,800, and a total cost reduction of $1,120,000,000.[1]

My reasons for advocating this goal are twofold. First, it would solve Vermont's health care affordability problem. And second, the industrialized nations mentioned above have proven that superior health outcomes can be achieved at this cost. In my view, it is masochistic—self-destructive—for us to continue to spend the kind of money we are now spending. It is as if we are taxing each person an extra $1,800 per year with essentially nothing to show for it!

So how do we go about achieving this cost reduction? It is my view that in order to reach this goal, a health care reform plan needs a sustained reduction in costs that are achievable today by focusing on the following areas:

- *Reduce the need for health care by keeping people well.* In this area of potential cost savings are all the activities that we commonly refer to as "wellness." Included in this broad category are immunizations, preventive care, and all the efforts that are described as healthy lifestyles. The results of success in this area would be an eventual dramatic decrease in type two diabetes, cardiovascular disease, and lifestyle-related cancers. On the flipside, those who avoided those diseases would experience enhanced quality of life.
- *Eliminate the delivery of unnecessary health care and ineffective health care.* The Institute of Medicine estimates that correct diagnosis and treatment only happen about 50 percent of the time. The result of success in this area would be a substantial reduction in clinical and medical costs, as well as an improvement in the patient's experience.
- *Reduce medical-error-related costs by improving the quality of health care delivery.* The Institute of Medicine estimates that 48,000 to 98,000 people die, and hundreds of thousands of people are injured, every year in the United States as a result of their medical care. Substantial costs are clearly associated with patient injury and resulting fatality.
- *Redesign the health care processes to improve efficiency in administration and delivery of services.* In this area, the potential cost savings will be driven by the effective application of information technology on process redesign. This process redesign will be possible in all areas of health care and wellness including diagnostics, treatment selection, patient records, patient education, communication, quality control, patient involvement in their own health maintenance, and financial reimbursement.
- *Make cost/benefit analysis a part of treatment decisions.* While this approach can be controversial, it is my view that it has to be a part of the health care decision-making process that leads to reduced costs. The challenge is to agree on how to quantify the value of the benefit element in cost /benefit.

At this point, I do not have definite estimates as to the percent reductions in health care costs that would be achieved over time from each of these areas of focus, but I am comfortable in estimating that a 35 percent reduction is achievable, if we are willing to implement the health care reform measures that are laid out above.

*Otto Engelberth is the founder and CEO of Engelberth Construction, Inc., a general contracting firm founded in 197, currently employing more than 250 people. He is a member of the Vermont Business Roundtable and serves on the Dartmouth Hitchcock Medical Center's Assembly of Overseers. His personal blog on health care can be found at: http://ottoengelberth.blogspot.com/.*

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[1] These figures were developed in 2005.

## Going Forward
## Con Hogan

Vermont made a run at health care reform over the last two years and ended up passing the Catamount bill. Much energy and work is being applied to the two main aspects of the bill, namely enrolling people who cannot currently afford health care into a health care plan, and putting together the machinery to apply managed care techniques to about three quarters of the Vermont population diagnosed with a chronic disease.

Given the above realities, the following is my projection as to what will happen on the health care front, at the state and federal level, as we go forward:

- The cost of health care will continue increasing at rates of between 8 and 10 percent each year, in an environment where there is not a 'system' that can be reasonably shaped and controlled.
- These ever-rising costs will have certain consequences.
    - At the continuing rate of increase, the overall cost of health care will double by 2012.
    - These rapidly rising costs, when combined with other severe economic pressures facing the middle class, will result in ever more people forgoing health care coverage because they simply will not be able to afford it.
    - The above dynamics will result in state government having to appropriate more and more to this cause, simply to stay even with the rising uninsured, at the expense of other pressing needs, such as property tax reform, transportation, and the other legitimate functions of government. The cost of health care simply overwhelms all other costs.
- Primary care physicians, who are the backbone of health care, will be under increasing bureaucratic and financial pressure. When one looks at a combination of declining numbers of physicians entering primary care, combined with the rapidly aging primary care work force, it is not hard to predict a serious shortage of these key players in the relatively near future. This is important because an adequate supply of primary care physicians are inextricably linked to higher quality and lower relative cost.
- In Vermont, the rising cost of Medicaid will be slightly checked by a variety of cost control techniques, but not enough to slow the overall engine of increasing health care costs.
- The Medicaid Global Commitment will continue to be perceived as good policy, until the loss of traditional firewalls between long term care and other Medicaid expenditures results in a decline of resources for elder services, and a decline in the quality of those services.
- At the national level, there will be significant progress in providing coverage for children, with the federal government playing a stronger fiscal role.
- In the meantime, the current trend of the number of adults lacking coverage will continue to increase nationally, as well as in Vermont.
- The Federal Government will also make progress in reducing the costs of pharmaceuticals through amendments to Medicare Part D, and other methods.
- The impact that the cost of health care has on the burden of business and its ability to compete globally will become clearer and more worrisome.
- Federally, the cost of Medicare will greatly increase, primarily as a result of the rapid aging of the general population. However, because of population demographic shifting, Medicare will become an untouchable social security-type "political third rail."
- At both the state and federal levels, the overall proportion of health care paid for by government will continue to increase.
- On the political front, Vermont administrations and legislatures will not want to deal with health care issues in any substantial manner, in that the prevailing political mood is to give Catamount a chance

to work, with a generally hands off cycle lasting another four to five years.

- By 2012, health care costs will have doubled, with quality issues coming to the fore.
- All this will set the stage for a "Medicare for All" political upheaval both at the state and federal levels, finally resulting in the creation of a health care system, primarily financed with broad based taxes, that has a chance of being shaped and controlled.

This is a scenario that sees change as a response to major trends such as those outlined above. The problem is so large, complex, and intractable that common-sense planning, ordinary coalition building, and incremental steps forward in the political process have not worked and, in fact, cannot work. What will cause change is the accumulation of trends, such as outlined above, that will bring the health care system close to a fiscal and quality meltdown. Only then will there be enough political will for major change, driven by broad based demand from those outside the health care system.

*Con Hogan is a former Vermont Secretary of Human Services. He chaired a Commission on Health Care Reform in 2000, and recently co-authored the book At the Crossroads: The Future of Health Care in Vermont.*

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## Designing a Health Care System: An Exercise – But Not in Futility

By Meg H. O'Donnell and Steven Kappel
UVM Adjunct Faculty, Master's of Public Administration

> A widespread desire for health care reform in the United States—and in Vermont in particular—is undeniable. Many advocate for reform based on the fact that the United States is the only country in the developed world without universal health care. Others are primarily concerned with controlling escalating costs. Fundamentally, however, real motivations become obscured by the politics of health care reform; the ideals of increased access or reduced cost are challenged by questions of political feasibility. The elusive balance between ideals and pragmatism is sought in any public policy endeavor.[1]

Vermonters have long wrestled with the challenge of maintaining a high-quality, financially sustainable health care system that is accessible to all who need it. The Coalition 21 effort and the many reforms enacted by the Vermont Legislature in the spring of 2006 are only the most recent efforts, and we are already wondering whether we've gone far enough or fast enough.

For five years, the capstone project in the graduate course on health care policy that we teach at the University of Vermont has asked teams of students to design a health care system that is affordable, available, and of high quality. In so doing, we ask them to build upon the foundation of our semester-long discussions on the elements of our health care system and the underlying policy forces that affect them, and to proceed from there to what they believe health care reform should entail. Students are expected to analyze their proposals not only from the aspects of the three basic perspectives of health care—cost, quality and access—but their feasibility.

This is, as you can well imagine, a challenging project. It's easy to say what an ideal system should look like. In class discussion, we find that most of us agree on the failures of our current health care system. They're easily catalogued: the number of people without insurance; the lack of access to preventive and primary care; the gaps in care resulting from a system that was developed not through centralized planning but by

[1] Emma Wright, "UniVermont: A Universal Health Care Access Plan for the State of Vermont" (Dec. 11, 2006).

multiple stakeholders, all of whom have a different interest in it. And not surprisingly, what has proved hard in real life—finding meaningful solutions that all of us can agree on—has also proved difficult as an academic exercise.

The above quote, from one of our graduate students' papers, expressively captures the challenges the class faces as they consider how to design a new health care system. What do we expect from "reform"? What goals are we trying to achieve? And how can we—or perhaps the question is, can we? —find that delicate balance between our ideals and pragmatic political solutions?

Health care reform is a values-based exercise. What each of us believes is necessary to improve health care depends in large part on what we expect our health care system to do for us. One of the most eye-opening exercises our students engage in, both during the class and as they work together in teams to develop their ideal systems, is identifying and trying to agree on what the driving values of a health care system ought to be.

> Establishing the goals of our system proved a challenging task. It was not that our values were drastically different from one another but all of our visions encompassed different definitions of what each of the goals meant. I found it shocking how challenging it was for a small group to reach a consensus on a definition for things such as equity, equality, or quality. In trying to reach a consensus we quickly found that we would need to let go of little discrepancies to settle on larger matters. However, the discrepancies found in our definitions and goals maintained relevance in practical matters of implementation. Differences in our visions of what equity and quality are defined as continued to cause disagreements. This exercise certainly made apparent how challenging it would be to reach a consensus on the best possible health care system in a country made up of individuals with such diverse values and life experience.[2]

Potential goals for an ideal health care system are many. We find that most students prioritize equity, with quality, choice, affordability and availability not far behind. But in designing their systems, they soon realize that not all of us prioritize these goals in the same way—nor, in fact, do we always agree on what those goals really mean.

> Language can clarify or confuse; it can help to unite us or divide us.[3]

Despite this, our teams of students do manage to come together, every year, and develop thoughtful proposals for reforming health care. Some take what they consider the high road—starting anew with a system that everyone pays for and everyone participates in. Yet those are the systems that the students themselves admit are not feasible in the United States we live in today.

> For this plan to be feasible, the entire health care system in the United States would have to be re-invented. It would require a paradigm shift about how Americans—and politicians—feel about health care.[4]

Barriers that students identify include the need to reform federal laws, like ERISA[5] and the laws governing Medicare and Medicaid, as well as the need to better engage individuals in their own health care through educational efforts and the like.

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[2] Allie Calnan, "The FATED Health Care System" (Dec. 2006).

[3] Vermonters Working Together and Speaking Out on Health Care Reform (The Snelling Center for Government, April 2006).

[4] Robert Fuller, M.D., "Critical Review of Presented Healthcare Plan for PA 325" (Dec. 2006).

[5] The Employee Retirement Income and Security Act, which (among other things) prohibits states from mandating or interfering with employer-sponsored benefit plans, including health plans.

> I was frustrated at the impasse we reached when trying to initiate our health care system. Even if we didn't initiate it all at once, but tried to incrementally introduce the proposed changes, the need to reorganize large parts of financing, ownership and responsibility made it impossible.[6]

While some of our students approach this exercise from a national perspective—by crafting a proposal to reform the country's health care system at the federal level—some have chosen to focus only on Vermont, on the premise that change is easier to accomplish at a local level. Recognizing the obstacles that only federal action can influence, this has generally led them to adopt an incremental approach to reform.

> To create the most idealistic health care policy, it would be necessary to undermine the current system. Arguably, this would have presented our group with the most opportunity to be creative and unique, as an unwritten paper reveals endless possibilities. However, we decided to work within the constraints of the current system, approaching reform based on potential feasibility.[7]

> Other [teams' reform plans] propose both idealistically grander and more systemic changes to the current health care system than does [ours]. All of these other plans focus on the U.S. as a whole rather than an individual state. While their plans are ambitious and illustrate some sound options for achieving the primary goals of health care reform, they have sacrificed feasibility for these ideals. [Our plan], conversely, has compromised ideals for feasibility. The struggle for a balance between these two concerns will always be a challenge of health care policy but hopefully not an insurmountable one.[8]

In the end, no matter the position on reform the students eventually proffer, they find this exercise a valuable one. It teaches many of the basic skills of policy development, like the willingness to discuss difficult issues with respect for others' beliefs and views. It reinforces the need to base policy decisions on facts, not anecdotes. It throws into stark relief the reality that public policy involves choices and trade-offs—one of the reasons that reforming health care is so challenging.

> "Every policy issue involves the distribution of something. There wouldn't be a policy conflict if there were not some advantage to protect or some loss to prevent." Vermont, being a small state without great wealth or taxable resources, has only limited means in which to fund programs for the public good (*i.e.*, public education, roads and bridges, environmental protection, Medicaid, and universal health care.) As a result, developing policies for the allocation of these goods can and often does involve a significant degree of political trade-offs necessary to get the policies approved.[9]

So what lessons can we learn from our students? First, that there is great value in understanding the policy implications of the health care reform debate. It will likely be difficult, if not impossible, to transform Vermont's health care system without change at the federal level that enables that transformation. Second, that any change will involve balancing personal and political interests and beliefs, as well as some trade-offs. Most importantly, it reminds us that public discussion and dialogue needs to be informed and respectful—something that we're pretty good at here in Vermont. What we can accomplish in a classroom setting, we can accomplish in the many other venues where people who care about policy issues gather, whether they are town meetings, study circles, coffeehouse talk, or legislative committee rooms.

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[6] Lydia Ehmann, "Back to the Basics" (Dec. 11, 2006).

[7] Kit Vreeland, "Summary and Critical Analysis of UniVermont" (Dec. 11, 2006).

[8] Emma Wright, "UniVermont: A Universal Health Care Access Plan for the State of Vermont" (Dec. 11, 2006).

[9] Jon Jewett, "UniVermont: A Health Care Proposal for Vermont" (Dec. 11, 2006) (quoting Deborah Stone, *Policy Paradox: The Art of Political Decision Making* [rev. ed. 2002]).

# 2006 HEALTH CARE REFORM INITIATIVES

# QUICK OVERVIEW

This summary is taken from the State Legislature's Web site:
http://www.leg.state.vt.us/HealthCare/2006LegAction.htm
More complete details on Act 190 and Act 191, which encompass the reform initiatives, can be accessed from this page along with a history of the formation of the acts.

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

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

## MAKING HEALTH INSURANCE AFFORDABLE AND ACCESSIBLE TO THE UNINSURED

- The act establishes a health insurance program called Catamount Health. Under this plan, everyone who is uninsured for at least 12 months will have access to—and will help pay for—a comprehensive health insurance package. The benefits will be administered through the private market and premiums will be based on income. Under the plan, everyone will pay their fair share through an affordable premium structure. In addition, employers will pay an assessment based on the number of their employees who are uninsured. We estimate that at least 25,000 Vermonters who are now uninsured will obtain health coverage.

- Benefits of Catamount Health include:
    - Primary care, preventive and chronic care, acute episodic care, and hospital services.
    - Reimbursement for medical services equal to ten percent above cost.
    - 25,000 estimated to enroll, including new Medicaid enrollment.
    - Chronic care management.
- The financing of Catamount Health is fair and fiscally responsible:
    - Based on the principle that everybody is covered and everybody pays.
    - Individuals pay sliding scale premiums based on income.
    - Employers pay an assessment based on the number of their employees (measured as full time equivalents) who are uninsured, exempting the first eight FTEs in fiscal years 2007 and 2008, six FTES in 2009, and four FTES in and after 2010.
    - Other revenues applied from increases in tobacco taxes and through matching federal dollars.
    - State fiscal obligations protected through caps on enrollment.

## IMPROVING HOW WE DELIVER HEALTH CARE

- The act helps deliver the right care at the right time to the most expensive health care consumers—those with chronic conditions. It makes chronic care management available to every Vermonter, whether privately insured, covered under a public program, or currently uninsured. Chronic conditions consume 70 percent of the cost of health care in Vermont. Chronic conditions are what Vermonters worry about most.

- The plan will establish an outstanding system of chronic care management. This system—available to all Vermonters—will provide:
    - Early and coordinated screening for chronic conditions like diabetes or asthma.
    - Better management of chronic care.
    - Emphasis on patient self-management.
    - Payment to providers that rewards quality of care and disease management, not just quantity. The system will reimburse providers for doing what we want them to do for those with chronic conditions—manage their care. For example, calling patients and reminding them to come in for regular check-ups, visiting patients in their home, and doing the necessary follow up.
- The act also codifies the Vermont "Blueprint for Health" prevention and chronic-disease management plan, and directs chronic care management in Medicaid and Catamount Health that will save an estimated 5-10 percent in health care costs.

**EMPLOYER SPONSORED INSURANCE INITIATIVE**

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

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

**MEDICAID INITIATIVES**

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

**COMMON SENSE INITIATIVES**

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

**Executive Branch Reform Coordination**

The Secretary of Administration will coordinate the health care reform initiatives, including Blueprint for Health; information technology—VITL, multi-payer database, common claims and credentialing forms; public health initiatives—Medicaid, VHAP, Dr. Dynasaur, and Catamount Health.

**Legislative Oversight and Next Steps**

- The Commission on Health Care Reform is charged with monitoring health care reform and will report on a plan to increase health care coverage to ensure universal access no later than 2011.
    - The commission is codified and remains in existence until 2011.

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

On December 1, 2006, The Secretary of Administration presented a Five Year Implementation Plan to:
GOVERNOR JAMES H. DOUGLAS
LEGISLATIVE COMMISSION ON HEALTH CARE
HEALTH ACCESS OVERSIGHT COMMITTEE
HOUSE COMMITTEE ON HEALTH CARE
SENATE COMMITTEE ON HEALTH AND WELFARE
SENATE COMMITTEE ON FINANCE

[The full document can be found at: http://www.adm.state.vt.us/pdf/hcr5-yearstrategicplan.pdf]

# HEALTH CARE REFORM BACKGROUND

## INTRODUCTION

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 provide the foundation for Vermont's Health Care Reform Plan, augmented by portions of Act 215 (the Fiscal Year 2007 State Appropriations Act), Act 142 (Establishing a SorryWorks! Program), and Act 153 (Safe Staffing and Quality Patient Care). Together, this comprehensive package of health care reform legislation is based on the following principles.(Act 191, Section 1)

> (1) It is the policy of the state of Vermont to ensure universal access to and coverage for essential health care services for all Vermonters.
> (2) Health care coverage needs to be comprehensive and continuous.
> (3) Vermont's health delivery system must model continuous improvement of health care quality and safety.
> (4) The financing of health care in Vermont must be sufficient, equitable, fair, and sustainable.
> (5) Built-in accountability for quality, cost, access, and participation must be the hallmark of Vermont's health care system.
> (6) 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 is 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 2006 Health Care Reform Plan is the product of extensive negotiation and collaboration by the Douglas Administration, legislative leaders of the Vermont General Assembly, and the private sector participants 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 is comprehensive in its breadth and significant in its potential impact on health care in Vermont. There also is a commitment to move forward with implementation in a collaborative, non-partisan manner to maximize its success.

## OVERVIEW OF FIVE-YEAR IMPLEMENTATION PLAN

Act 191 assigns responsibility to the Secretary of Administration for coordination of health care system reform among the executive branch agencies, departments, and offices in a manner that is timely, patient-centered, and seeks to improve the quality and affordability of patient care. *(Sec. 3. 3 V.S.A. § 2222a)*
As part of this responsiblity, the Secretary is required to submit a five-year plan for implementing Vermont's health care system reform initiatives, together with any recommendations for administration or legislation, to the Governor and legislative

committees on or before December 1, 2006. The Secretary also is required to report annually to the general assembly on the progress of the reform initiatives, beginning on January 15, 2007.

There are more than thirty-five separate initiatives contained in the legislation that forms Vermont's 2006 Health Care Reform agenda. All initiatives are in some way are related to all three of the health care reform goals:

1) increasing access to affordable health insurance for all Vermonters;
2) improving quality of care across the lifespan; and
3) containing health care costs. These three goals also are all related to each other.

For detailed information about Vermont's Health Care Reform Implementation, please go to http://hcr.Vermont.gov.

The web site is maintained by the Director of Health Care Reform Implementation in the Agency of Administration, and is a thorough and up-to-date resource for Vermonters to find out about the status of health care reform efforts. You will find new and updated information about health care reform on this site.

## Questions for the continuing conversation on Health Care Reform in Vermont

Any plan to reform or transform the health care system in Vermont is not a short term endeavor. It is in fact a continuing conversation that goes beyond legislative sessions and election cycles. Some of the key questions to ask about proposals and actions in the years to come include:

- Does the proposal or program eliminate barriers to care? Provide health care for all Vermonters or clearly move in that direction? Facilitate full participation by all Vermonters?
- Will it ensure access to essential health care services irrespective of age, income, employment or health status?
- Does it support the development of an integrated system of care and administration, and facilitate continuous measurement of and feedback on quality and health outcomes?
- Is what we will contribute financially based on ability to pay? Does it eliminate financial barriers to essential health care services? Is it sustainable?
- Will the funding of the system encourage the outcomes we want (e.g., will we pay for health or sickness)?
- Are clear partnerships established between the health care system and individuals that promote good health, emphasize prevention and wellness, and focus on good management of chronic conditions?

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