Health Care Reform 2005

A process of engagement by The Joint Committee on Health Care The Vermont Legislature

Organized and facilitated by The Snelling Center for Government

During the 2005 legislative session members of the House Committee on Health Care[1] and the Senate Health and Welfare Committee invested an enormous amount of time learning, researching and analyzing issues related to the health systems serving Vermont. A number of experts and interest groups had provided testimony to the committees about the many issues and many perspectives on how best to address them. Committee members were concerned, however, that perspectives from significant segments of Vermont's communities were missing in a process that was moving toward transformative change. Despite many individual conversations with constituents, broad engagement from average citizens, small businesses, nonprofits, and/or local governments statewide had not yet been rigorously incorporated into their deliberations.

Even before the final formulation of the bill that passed the Vermont House and Senate (H.524)[2] committee members expressed a desire to share with Vermonters the learning that had led them to their initial conclusions and the assumptions that underlay the legislation. And so, in the spring of 2005 The Snelling Center for Government[3] was asked to outline ideas for a possible public engagement process to more broadly involve Vermonters in the deliberations on reforming the systems for delivering and paying for health care.

The request to The Snelling Center to plan, conduct and evaluate the "public engagement process" for health care reform was based on the requirement in Sec. 277e of Act 71 of the 2005 Legislative Session. That law provides: *"In recognition of the importance of public engagement, the House Committee on Health Care and the Senate Committee on Health and Welfare [the Joint Committee] shall have six public hearings during the interim of the 2005 legislative session to solicit input from citizens, employers, hospitals, health care professionals, insurers, other stakeholders and interested parties about health care reform."* Over the summer The Snelling Center worked with members of the legislative committees to develop a process of civic engagement expanding the conversation on health care reform to the Vermont citizenry.

The legislature requested that the process advance an authentic dialogue with the public so that legislators could listen to and engage with Vermonters who are ordinarily not present in Montpelier during legislative sessions and whose voices are not heard in any organized manner.

[1] The House Committee on Health Care was a newly established committee in the Vermont House in January 2005.
[2] http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/bills/passed/H-524.HTM
[3] http://www.snellingcenter.org/

The Center viewed this request as a multifaceted set of opportunities for conversation, dialogue and education, as well as an expression of ideas, concerns and hopes of Vermonters.

The authorizing legislation specified conducting six "hearings" in different regions of the state. Working within this limitation, and seeking locations that would reflect the diversity of the Vermont citizenry, it was agreed that efforts would be hosted in Springfield, Rutland, Lyndonville/St. Johnsbury, Bennington, Chittenden County and Barre.

Knowing that people bring specific, diverse and conflicting perspectives with them to any process, each day and the overall engagement program were designed to capture and document these perspectives in multiple ways.

The six days of engagement were designed so that each had four distinct opportunities for engagement:

- Lunch sessions organized by local community leadership;
- Focused and structured conversations with small groups of specific stakeholders (e.g., employers, providers) hosted and facilitated directly by The Snelling Center; and
- Open public sessions in the evening with both an opportunity for dialogue, education and direct engagement between individual committee members and the public, and
- The more traditional opportunity for public comment.

(For a more expansive discussion of the methods of engagement see Appendix III).

There were many opportunities for the public to offer suggestions, express concerns and ideas, or ask questions both at the events during each day and through a website and write in opportunity created by legislative staff. Organized public engagement efforts, such as that designed by The Snelling Center, provide additional dimensions in that the conversations are documented and create a shared learning experience for legislators who will continue to work together, and between legislators and a wider group of Vermonters. People willing to talk together, is an important step in growing civic engagement. People willing to learn together, is a larger step toward advancing a positive Vermont public policy environment.

Approximately 800 Vermonters participated over the six days. The process met the specific legislative intent to "solicit input from citizens, employers, hospitals, health care professionals, insurers, other stakeholders and interested parties about health care reform." At the end of the process, the challenge for The Snelling Center was to determine how to summarize the comments and draw out the themes from the many conversations and summarize them in a report to the Joint Committee. More than 200 pages of notes from the various sessions and forty hours of recorded conversations compose the raw data compiled from the process. The Snelling Center staff worked with the professional facilitators who ran the afternoon focus groups to identify themes and trends from those conversations. These were combined as possible with the comments and notes from the evening public meetings. Comments from lunch conversations as well as independently submitted information were also included where appropriate.

These themes, ideas, and the guidance for continued deliberation on moving health care reform forward in Vermont are the subject of the body of the report that follows. The process was not

designed to nor did it result in "solutions" or specific proposals. Instead it connected members of the Joint Committee who had been immersed in their own conversations directly with the thoughts, hopes and fears of Vermonters. Also it helped to embed the conversation more deeply with the citizens themselves.

Pierce Butler, a delegate from South Carolina to the Constitutional Convention in 1787, is credited with saying that the purpose of the convention was not to provide Americans with the best government, but rather to design the best government that Americans would accept. Having designed, facilitated and observed this most recent process of public engagement, we believe this is a good operating principle and can be applied to the work on healthcare system reform. The legislature's task is not to design a new system that is theoretically the best that can be found, but rather through engagement with the public, to find points of common agreement and acceptance, to make a better system of health care possible. At least in part, success will be due to the process that brings us to a better system, and through that process by the ownership of that system by the people it will serve.

Presented by The Snelling Center for Government

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Listening for Unifying Themes

In any process of public engagement designed to guide and support the formation of public policy, policy makers hope that clear themes will emerge that can provide a quantifiable base upon which to move specific policies into place. Policy makers, whether legislators or members of executive branch agencies, seek to design programs and services to increase the public good preferably with public understanding and support solidly behind it. Obtaining that public consensus is a difficult and elusive process.

When designing this process for the legislature, The Snelling Center had already examined earlier efforts and worked through its facilitation of Coalition 21 to document and provide information on previous health reform efforts. Many of these previous efforts had also attempted to discern and quantify public thinking. Such efforts include, but are not limited to:[4]

- *Hard Choices in Health Care 2002: What Vermonters are Thinking*
  A Report to the Commission on the Public's Health Care Values and Priorities
- *Governor's Bipartisan Commission on Health Care Availability & Affordability*
  Final Report - December 4, 2001
- *Universal Access Plans*
  Report of the Health Care Authority to the General Assembly (November 1993)

The current effort by the legislature must be set in the context of the findings from these previous efforts and must take into account both the evolution of thinking by Vermonters and the readily apparent thematic consistency.

Of these earlier efforts, the one most similar to the current process was that employed by the Commission on the Public's Health Care Values and Priorities (1994-1996 and 2000-2002). Three key findings were reported by the Commission in 2002 that demonstrated a continuity of agreement among Vermonters from 1996. Those findings included:

1. Two-thirds of Vermonters surveyed in 1996 and 2002 would pay both higher taxes and more for health insurance to provide coverage for everyone.
2. Support for taxpayer-funded health insurance (Medicare and Medicaid) remains rock solid.
3. Seventy-one percent of Vermonters in 1996 and 75 percent in 2002 believe that those receiving taxpayer-funded health care should pay at least some of the cost of their health care based on the situation and their ability to pay.

There is nothing that emerged from the 2005 conversations with Vermonters that contradicts the findings of the 2002 report. If anything these findings are further reinforced through the AARP survey of Vermonters conducted in June 2005.[5]

[4] Copies of these reports can be found at: http://www.snellingcenter.org/coalition21/vtresources.html

[5] http://www.aarp.org/research/health/privinsurance/vt_coverage.html
About half of residents describe the state of health care in Vermont as having major problems—or worse, being in a state of crisis; More than three-quarters believe it is extremely or very important for Vermont to reduce the number of resident without insurance, and most believe it is extremely or very important for

Vermonters are willing to look beyond ideological positions, to learn, and to provide appropriate input into legislative deliberations. To do this they need to be kept engaged both through and beyond the many interest groups that crowd the table during the legislative session. Generally themes, ideas and thoughts captured in this most recent process concur with the 2002 findings that "Vermonters may have conflicting feelings or their attitudes may be incompletely or poorly informed. In both cases, people will need time and opportunity to work throughout their thinking to reach a considered judgment about these issues."

In Vermont, we have a history of and structures that support public debate and deliberation over important social issues. These range from a relatively open, non-bureaucratic state government, to a "citizen" legislature, to active networks of non-governmental organizations, to town meeting forums. Steps that will significantly alter how individuals and institutions relate to health care and receive direct services should be presented within an educational framework that allows Vermonters an opportunity to engage with the system change rather than feel it is being imposed.

The Snelling Center has organized the search for themes and key issues into three. We will start with the collected ideas and concerns from the open, evening sessions, then move to an exploration of the focused conversations where the publics were grouped by function and had a chance to explore this issue in a structured manner. Finally, the compilation of results will be organized around the "drivers" of health care reform identified by the legislature. Integrated into the first section is some of the feedback provided by citizens directly by mail and email or in other notes to legislators.[6] As the process organized by The Snelling Center wrapped up, other groups continued conversations and additional ideas and perspectives are being gathered by other efforts.[7]

There is no simple bulleted way in which to present summary results of this process. We can talk about the success of the process itself, reflected in part by the numerous thanks that legislators and staff received for hosting a "different" way to learn together. Not surprisingly, citizens value engaging at a time when there is more to talk about than simply whether they support or oppose a particular proposal. Yet, such up or down votes on proposals or plans is all too frequently what passes for "engaging the public." People like to have the sense that they have been asked what they think early in a process, especially when the outcomes so directly impact their lives. Given the chance, people listen, ask questions and learn. If the engagement process works well, people own and then continue to build on policies and programs that are generated from such root.

During this process we heard that there is indeed a sense of "urgency" to move ahead. People are looking for something that will be significantly different and responsive to the "needs"

Vermont to make health care more affordable for all residents; More than eight in ten agree that all Vermonters should have access to the same basic health care coverage, and nearly as many think that everyone, including employers, employees, and the government should contribute to a system so that everyone can have the same basic health care coverage.

[6] Citizens were able to send email directly to the legislature or were guided to respond to the same questions that the public addressed in the open public dialogue sessions by following the information on the Legislature's health care public engagement web site: http://www.leg.state.vt.us/Public%20Engagement%20Forums/PUBEngDates.htm

[7] See Appendix V for a sample of a forum organized as a follow-up to the legislative process.

articulated. That urgency was most clearly expressed in the open public forums. In the more focused conversations with small groups of stakeholders most people expressed more than just a desire to improve the current system.

There was less agreement on the specifics, but there was a strong sense that Vermonters by and large agree that no Vermonter should be denied access to health care, and that health care should be more than basic or emergency care. There was general agreement that everyone should participate in the system and that everyone should also contribute financially in some way. There is universal concern that rising costs jeopardize access and quality for all and specific actions need to be taken to reduce cost increases. Finally, there was near universal agreement that the quality of health care in the state is basically good and that system reform should not jeopardize that quality. In particular, Vermonters want care close to home. The network of community hospitals received much support, but participants generally agreed that it should be expanded by other services to make sure people have access to appropriate services at appropriate times and places.

After listening to these conversations in multiple venues, some committee members remarked that citizens' hopes and desires echoed the major themes in the legislation even though many of those citizens had never read H.524.

In the next three sections the different types of conversations will be summarized and the ideas and thoughts from those conversations will be presented.

I. OPEN DIALOGUES AND CONVERSATIONS WITH THE PUBLIC

Over six evenings in locations throughout the state, the public was invited to participate in individual and informal conversations with committee members and local legislators, and to provide public comment in a more traditional "hearing" format. This was an open invitation extended to the public through local media, announcements to stakeholder groups, and through local legislators. Approximately 440 individuals attended these sessions. In the context of these freer flowing conversations, The Snelling Center set up a structure to provide for educational dialogue between members of the public and committee members, and some structured ways for people to record their thoughts, concerns and ideas.

Some stakeholders (e.g., health care providers, employers, etc.) were present, but for the most part these sessions were attended by people who came as individual consumers of health care services. The discussions and comments were largely drawn from personal experience. A number of personal stories were offered, but more often than not people who spoke directed their comments through the framework presented by the educational kiosks[8] and questions.

While many of the themes that were presented had much in common with the discussions earlier in the day, they were couched in terms that were more personal. When people spoke from their position in a stakeholder group (as an employer, provider, administrator, etc.) they discussed issues in the context of various degrees of importance, but in most cases there was a sense of having a choice, even if it was not a good one. Employers could opt out of paying premiums or go to a health savings account program. Physicians could continue to deliver care, even if they wanted the ability to do more or do it differently. In contrast, for those who came as individual consumers, the discussion was not about choice, but rather about health, about pain, about care for a parent or a child. It was direct and personal. There was a consistent expression of urgency about their situations.

In listening to people and reading their comments we note that there were many terms or words used to describe issues, conditions and proposals that had different meaning depending on who was expressing them. One term is often used, even by the same person, to mean very different things, leaving it up to multiple interpretations. When they talk about *access, personal responsibility, choices, universal access, accountability, affordability, outcomes* and *local*, there are different interpretations depending on one's viewpoint. A key learning for legislators is that as they talk about and write about transforming the system, they need to be careful to use precise and well-defined terms, and to do so consistently. It is important now that the legislature takes care to explain their terms and the context for actions, to make transparent their assumptions and to help bring people along in the process through building a common language and understanding. Legislators very much need to act as translators, bringing together the many different languages and usages of terms that permeate the discussions.

[8] The kiosks were educational poster boards with key information on what the legislature learned through its investigation of the key drivers for health care reform. The information from the posters is summarized in Appendix VI.

Key Issues found in most, if not all, conversations as common elements

- People spoke with a sense of urgency. *The system is broken. It is not serving us*. We may not agree on how to fix it but there needs to be a set of clear steps that will address some of the most important issues.
- People are impatient. *Why are we still talking about this, and not moving ahead? We want and the system needs us to have everyone covered and participating, why isn't it happening – this is not a new conversation, lets move on and deal with the other issues that we need to address.*
- Be bold, be cautious. There was a desire to step out in front of this problem in a big way. It is beyond small fixes. Set up a framework to move ahead, but in those areas where there will be major changes in how people access the system or what they get from it, test the change before getting in too deep without an exit strategy.
- Don't damage the existing quality of care.
- Keep the community based hospitals open. We want that level of care close to home.
- All Vermonters should be able to expect access to the same level and quality of care no matter where they live. If there is to be a basic health care plan, it should still be comprehensive and acknowledge that health is a multi-faceted field that needs to treat the whole individual. Specifically, mental health, complementary care, eye care, dental care were all regularly mentioned as parts of health care that need to somehow be encompassed in "basic."
- Prevention should be better (fully) integrated into how we deliver health care. Prevention is necessary for the system to work to provide the best quality, and in the long term will mean lower costs.
- Simplicity is a key concept when people speak about how they want to access the system and pay for it. More direct access. Less paperwork. More integration. More communication within the system.
- Specifically need to address the high cost of prescription drugs.

Other public engagement around the health care reform drivers

Below are more specific comments and quotes that illustrate how people expressed their hopes, fears, and ideas on the reform questions. These were chosen for inclusion, as they are expressions that were found in at least two or more of the sessions but were not as universal or reducible to common issues such as those noted above. Some are summarized, but in as many cases as possible we let people's comments speak for themselves if their expression of an idea echoed a number of times in other comments.

<u>Access</u>

- *I think that I am one of the 10% of Vermonters who generate 70% of health care spending. I am a recipient of Medicare and Medicaid. Without these programs I would be living homeless on the street or dead. So please find a way to expand Medicare to cover everybody. (Rutland citizen)*
- Want more access as part of the local networks, given a choice people will go to an in-town clinic at 8pm if their child has an earache rather than drive 30 miles to go to the ER

- The current system provides disincentives to participate in the system responsibly. *We are raising a generation of young people who are disconnected with the health care providers. They get medical services when they are in emergency or other critical situations. (Barre citizen)*
- One basic package of benefits that all Vermonters can start with.
- *More primary care physicians and nurse practitioners have to be in the system. Need fewer specialists and more primary care doctors to make a difference in increasing access and curbing costs. (Retired doctor in Springfield)*
- *I have been fortunate. I have had employer provided health care for most of my life. I'm 53. Success to me would be that everyone experiences what I have. I believe universal access is the best route to take to achieve what I have had. (Springfield citizen)*

<u>Cost</u>

- Administrative costs are a major portion of health care spending. More choice / Less choice will reduce administrative costs. *Please explain how the administrative costs will go down. I can't see it happening. (Barre citizen)*
- Financial incentives should be available to encourage individuals to live healthy lifestyles
- *We also need to remember that even making good decisions, people do get sick. Some people are genetically or otherwise oriented to certain conditions or diseases (e.g., obesity) (Lyndonville citizen)*
- Financial incentives should be available to encourage providers to use best practices and demonstrate results
- *The decision should never be about cost but about care. (Lyndonville citizen)*
- Invest in those things that have the longest term benefit to cut costs and improve health, even if it means major investments today without immediate pay back (e.g., preventive care, chronic care, universal pre-natal care, free check-ups, in-school clinics)
- *Too many people hesitate to seek the right kind of care when they need it, and when it would mace a difference, as they are concerned about cost. They wait too long and either they do not need the care because they die, or they need even more and more expensive care. (Lyndonville citizen)*

<u>Financing</u>

- Simple, simple, simple
- Seamless - tighten the net - too many breaks
    - Kids graduate from high school or college and drop off of parent's plans before they can afford something on their own (or think that they need it)
    - Big holes in income sensitive programs, people off one program before they can "graduate" to another - keeps a vicious circle going of people on aid or uninsured. Kids are often caught in the middle. Lots of gaps in Medicare
- Financing should not be dependent on employment or employers (but employers should be part of the system)
- Government run systems can work (a number of people spoke from personal experience using or having family using systems in Canada, Europe, Australia, New Zealand).
- Government does not have to deliver care, just set up the structure to organize it and adequately finance it through equitable means

- Simple paperwork, not just for billing but for patients to understand what things cost
- More use of taxes on cigarettes, alcohol, junk food to fund system
- VHAP could work better, and could work in an expanded format out to small businesses and self-employed

Quality

- Education is critical; more time for providers to spend with patients and appropriate reimbursement
- More focus on safety and make sure there is funding to support it
- Focus on public health - especially nutrition, and minimization of problems from alcohol, tobacco and other drugs
- More / equal access to complementary care / alternative medicine
- Patient records are all together, electronic, and travel with them
- Need to encourage more cooperation and coordination within and across the system. The "system" parts should be able to talk to one another

Principles

- *Health care is at the core of the principles, not sick care. Health care is cheap. Sick care is expensive.*
- Universal access should mean getting good full care, not that one has access to the emergency room.
- Prevention is essential - should be on par with other "treatments"
- Health care is a "right" not a privilege
- *Access is a red herring. Get rid of the term. Focus on improving and measuring the actual health of all Vermonters. Nowhere in H524 do we explicitly state that our overall public policy goal is to provide good quality care to all Vermonters at the least overall total system cost (i.e., getting the biggest bang for our total money) in a way that is sustainable over time. (Burlington citizen)*
- Patient-centered system. *I want to see the system changed to be patient-centered and offer choices and incentives for making decisions that lower costs. (Rutland citizen)*
- Keep the discussion open. *Businesses understand that there is a need and there will be compromise. Everybody should be talking more. We all have an investment in this system and the outcomes. We should be talking together. (Springfield Business owner)*

Some assumptions and issues to address

In expressing their hopes, concerns and fears some assumptions were expressed very strongly, usually by an individual or a small number of individuals. Their strong expression of these assumptions offers an important lesson for legislators around why it is important to use exact language and explain terms no matter how straight forward and widely accepted we might think they are. They also raise concerns that should be directly addressed by the legislature in explaining why certain actions are taken and not others.

- *Universal access means a government-run, government controlled system*
- *Universal access means "single payer."*

- *Single payer means a government takeover of health care provision and decision-making.*

- *People in other states have choices of insurance. They can get cheaper insurance because they have a choice, including high deductible plans. If we just had more choice the whole system would benefit, as people would buy their own plan, be covered and it would be affordable.*

- *Universal access is not a good place to go. When government is involved, people will suffer, physicians will leave if fees are slashed, and people are told what they can and cannot do.*

II. FOCUSED CONVERSATIONS

Conversations with different stakeholder groups were convened by The Snelling Center and took place in each of the six locations. The legislature asked The Snelling Center to convene these small groups. The Center used local legislators in each region, as well as its own extensive network of graduates from its leadership programs to submit names of local citizens who might fit into an identified category and be a good discussant from that perspective. Specifically participants were sought (and 166 came) who were not likely to have already been involved with the legislature or represent interest groups who might be. Identified below are the groups convened in each location and the number of participants.

	Providers	Employers	Mixed*	Social Service	Labor
Springfield	X (7)	X (5)	X (8)		
Rutland	X (12)	X (7)	X (8)		
Lyndon/St.J.	X (5)	X (6)	X (5)		
Burlington	X (13)	X (11)	X (6)	X (5)	
Bennington	X (6)	X (9)	X (11)		
Barre	X (13)	X (10)	X (10)		X (7)

* The mixed group was composed of a composite of people who served in governing roles for nonprofit health care organizations, as health care office administrators responsible for interfacing with the financial system, and social service workers who assisted Vermonters in navigating the health care system. In Burlington, there was a critical mass of Social Service workers and a separate group was arranged.

The group conversations were organized around ten questions (Appendix IV) designed to: (1) Guide discussion to identify key themes that might or might not be present in distinct groups, locations or across all boundaries; and (2) Give participants the opportunity to speak from their role as an employer, provider, etc. The conversations brought many perspectives together. Some participants came to the table "scripted" with a list of ideas or particular political perspective, and others with a deeply personal story or experience. The hope was to be able to move through, or at least identify, the many assumptions that often embed themselves in daily conversation to a more open dialogue. It must be remembered that even though participants in these groups were all asked to come to the table and speak from a specific stakeholder vantage point (e.g., employer) they are also all individuals who have concerns and experience in dealing with their own personal health care and that of families and friends.

The following sections will provide an overview of the perspectives through the lens provided by each of the stakeholder groups. In the final section of the report all perspectives will be joined in examining them in the structured framework provided by the "drivers" of health care reform identified by the legislature.

(A) EMPLOYERS

Institutions that act as employers in Vermont are as diverse as any group. They include public sector (town, school districts), nonprofits, and private businesses from self-employed persons to businesses employing 6000 individuals.

Private sector employers were consistently clear that their focus has to be on meeting their business objectives. Concern over health care issues is largely focused on cost, in terms of how it affects their ability to meet those objectives. They connect these both to recruiting and retaining high quality and long-term employees, and the ability to ensure the stability, vitality and security of their company. Erratic, unpredictable and high rates of increases in health insurance affect their ability to plan and budget effectively for their business. Having insurance tied to employment is seen as a burden on business, and on employers of all types (including municipal, school districts and nonprofits). There was considerable discussion on the burden created both by high rates of increases in insurance premiums and the unpredictable nature of those increases.

Employers of all kinds are concerned about cost, though the cost they clearly understand and relate to are those in premiums and not in the system overall (though they generally understand the connection, voiced most vigorously in the perception that they were subsidizing state and federal programs through their premiums). Larger employers voiced concern over administrative costs, focusing on their own costs of deciding on plans for employees and managing those plans whether or not they are self-insured. There is a significant administrative infrastructure in business that needs to be maintained under employer-based health care. Smaller private sector employers (who were more represented in the evening programs and quite outspoken) and self-employed persons decried a lack of access to affordable health plans. One after another they declared that they were willing to pay their fair share for good health coverage, but perceived that they were paying much higher rates to buy it in the small business or individual market. For those employers who did offer health insurance to their employees there was concern that it put them at a competitive economic disadvantage with other businesses. Those businesses that did not offer health benefits were concerned that they could not stay in business and pay premiums for their employees. If they got to the point of profitability that allowed for this (and there was a desire to do this) then they were concerned they would then no longer be on a level playing field with other businesses that do not have that expense.

For all employers, good health coverage was an essential ingredient in maintaining employee satisfaction. For private businesses this was important but second to cost; for nonprofit employers this tended to be more important than cost. As a result these different types of employers would often move to different priorities in what they wanted the system to preserve or to eliminate.

A number of different issues divided employers, much more so than the other groups. One conclusion is that it would be difficult to claim that there is a single "employer" perspective on health care reform, or even a single "business" perspective. The discussion among employers was rich, and often the most extended, starting at lunch, continuing through the afternoon

focused conversations and lasting into the evening public sessions. Employers were concerned, engaged and vocal. They were also diverse in makeup and in their conclusions.

Key Issues found in most, if not all, conversations as common elements

- ***Disconnect/decouple employment and insurance***—an employer-based health care system does not work for employers or employees. It leads to cost shifting, reduces competitive edge for employers, and results in employees staying or leaving a job based on the need for benefits and not because it is a good fit.
- ***Portability in health insurance***—Insurance should be attached to the individual rather than the employer. This would increase access to care and reduce administrative burden —through less paperwork, less complexity, less negotiation with insurers and employees —and perhaps cost, to employers.
- ***If employers are in the business of providing health insurance, fair share should replace cost-shifting***—They want a level playing field with one another and want cost-shifting reduced; perhaps this means that they all must offer a minimum catastrophic package with the option of adding on more. NOTE: There was not agreement on this as some employers were strongly opposed to mandates on employers of any kind.
- ***Employers want predictability in costs and change*** –the current unpredictability with respect to cost and potential for systems change leave employers uneasy and unable to plan for the future
- ***Current costs are unsustainable—***Continued cost increases will put existing companies out of business or force them to relocate and cost will prevent future entrepreneurship
- ***Choice should be maintained***—Employers want choice on three levels
    - Choice of health insurance plan—gives employers flexibility in balancing costs and business objectives
    - Choice of health care providers—enhances employee satisfaction
    - Choice in benefits plans— allows employees and employers choice and ability to tailor to needs of the individual employee (e.g. through Health Savings Accounts)

<u>Concerns/Assumptions Regarding Competitive Edge</u>

Employers expressed their concern that they were not in the business of health care, that it takes a lot of time (especially in smaller businesses) but to be competitive they had to address it. Under the current system they found that:

- Offering rich benefits can attract great employees—therefore it can give a company an edge compared to other companies in getting talent that makes the company a success. Some companies like to distinguish themselves through benefit packages.
- Offering rich benefits can lead to the retaining of some unhappy employees who stay just for the benefits and therefore impede the success of the company
- Offering rich benefits is costly and makes companies less competitive (economically) with other companies that do not have this extra cost.

Employers expressed some concern that mandating benefits in Vermont might make Vermont companies less competitive nationally and internationally, however they did not have any specific examples of this because it has not happened yet. They did caution legislators about

making change that may lead companies to decide that it is too difficult to be competitive in Vermont (due to high cost, loss of quality employees, or loss of customer base) as they may choose to go across the border (state or national). There was general concern about competitive issues with companies in adjoining states that spilled over into a concern about health care.

Nonprofit employers had a different take on competitiveness. Nonprofit employers said spillover was not an issue for them, though some do offer services across state borders. They indicated that their operations are Vermont based and not mobile like for profit businesses. They recognized that success depends on the talent of employees and therefore there is competition for high quality employees. As they cannot compete with the private sector salaries, they sometimes use health care and other benefits to off-set low wages in attracting employees. They were more concerned, however, about reducing costs in order either to increase the number of employees and do more/better work or to offer more/higher benefits to existing employees.

Must haves and can't haves

When employers were asked, *If a health care system DOES NOT INCLUDE _____ I would not be able to support* they had a wide range of responses from individual benefit types to broader concerns about who pays. Their list however was as long and diverse as any other stakeholder group.

Predictably employers want lower costs, and do not want more costs shifted on to them for "fixing" the system. They want the system to be operated like a well-run business. If they are paying for it they want choice of plans and choice in how they participate. While their direct business concerns were strongly stated, most of their "wants" were related to ways that the system would perform for individuals. There is a strong emphasis on preventive care, incentives for healthy lifestyles, assurances that everyone would be in the system and everyone would pay, and a belief that the system would serve their employees well and that health care would be a source of less stress for their employees and their families.

When employers were asked what they WOULD NOT SUPPORT in any system, they were very specific and generated a much shorter list. Predictably, at the top of the list, employers would not support increased costs as they feel they already shoulder more than their fair share of the burden. They were concerned about more government "mandates" but did not delineate specifics. They were very concerned about the possibility of creating a new government bureaucracy to administer a universal system. Nor would they support changes that resulted in more administrative burdens.

Common experience of employers with Costs

When employers shared their direct experience with managing health care benefits as an employer five issues emerged from their stories.

- Employers who pay for benefits universally feel that they are picking up an **unfair share** of health care costs both for their employees with benefits and for the employees of other companies that do not offer benefits
- Part of the frustration for employers in paying an unfair share is that it is a result of **cost shifting** in the system, which to them is just bad business practice.
- Want **shared responsibility** for cost health care—shared by employers, employees, and all Vermonters—willing to pay if everyone is paying.
- Employers understand that their real costs are the premiums they pay plus **administrative costs** for processing benefits and time by human resources in negotiating benefits w/insurers and employees. The administration of benefits is time consuming and shifts their focus from business objectives to benefits administration.
- The rate of **increase is unpredictable** and rising too quickly.

Assumptions:

The following sets of assumptions are presented because they were mentioned a number of times in employer conversations. Unlike the comments above that emerged out of direct experience of an employer, these ideas emerged from statements like "I believe…," "I think…," I assume that…."

**** Costs are rising because of***

- Malpractice insurance
- Medical errors
- Workers compensation abuse
- Excess administration
- High public expectations for care services

**** Costs would go down if only***

- Individuals took more responsibility and had incentives for healthier lifestyles/decisions
- Everyone (consumers) paid so they recognize the cost of their choices—medications, procedures, lifestyle
- There was transparency in actual cost of a procedure it would lead individuals to make better (lower cost) choices
- There was a larger pool to lower per person cost and reduce cost-shifting
- There was a single administrator to reduce administrative costs

Employers are often simplistically portrayed as being against change. In fact, these conversations demonstrated a great deal of support for change in the health care system. Employers are very clear about some of the conditions of change, and are cautious and want to fully understand and be able to measure how that change will impact their business. Employers are also besieged with "information" on reform and come to the table with a number of preformed beliefs and ideas. Many of these are identified above and present an opportunity for further education and discussion.

(B) PROVIDERS

As with employers, providers in Vermont represent diverse fields and experiences. Physicians (both private and hospital practice), nurses, mental health providers, dentists, optometrists, chiropractors, community health workers, and practitioners of complementary medicine were all invited. The groups were designed to cut across assumptions that might permeate any small grouping of like practitioners. If any group was under represented in this (as in most conversations on health care reform) it was primary care physicians. One clear recommendation is that more effort be made to bring this group of care providers along with Family Nurse Practitioners into the conversation for their unique front-line experience.

In almost all cases the conversation started from and stayed focused on enhancing how the practitioner relates to the patient. "We do a lot of good for people. Change the system to enhance our work. Don't put new impediments in the way of us providing good care to people." Providers were universal in their concern for maintaining and increasing the quality of care that is available, and providing the most effective and timely care, as much as possible through evidence based practice. The need for chronic care programs (even more expansive than the current Vermont initiative) was assumed and supported as a practice that would allow more effective care to be delivered. The need for more opportunities to provide appropriate care in appropriate settings to prevent future problems was often discussed.

While the conversation was designed to keep providers focused on speaking from their role as providers, many of them are also employers. They have staff to recruit and maintain, and the cost and quality of benefits are an important part of that role. The discussion here was less about cost and more about the other administrative burdens. Unlike all of the other groups, insurance as a general or specific issue was not directly discussed.

Key Issues found in most, if not all, conversations as common elements

- ***Good care is delivered at the appropriate time and place*** --- The system should build in preventive care, from basic early childhood immunizations and wellness care, to ongoing education for parents and children, to more public health models for addressing diet, nutrition, exercise, screening and early detection. That these are central to the health system and not add-on programs, or programs relegated simply to personal choice.
- ***The health system should be an integrated system*** --- There is too much fragmentation in the system, between institutions and individual practitioners and the care needed. Individuals should be able to get what they need in an efficient and seamless manner through the sharing of patient records to referrals to authorization of care. In the end the care should be carefully coordinated so that there is never a question or assumption in what has happened or why. Integration should also be inclusive of mental health services and complementary care.
- ***Administrative requirements must be minimized*** --- Providers understand the necessity for documentation and record keeping, but respond to the steady increase in this as employers respond to the steady increase in premium rates. Universally they feel that time is being taken away from providing care and full attention to their patients through the necessity to draft or review paperwork required of an ever increasingly complex set of forms and reports needed largely for an overly complex reimbursement system.

- ***Reimbursement*** --- Most of the discussion about cost with providers centered not on system costs, but the lack of adequate reimbursement (primarily from state and federal programs) to cover the real costs of the services being delivered. Just as many employers felt that their premium costs were subsidizing the state programs, so too do providers feel that their low reimbursement rates are being used to unfairly fund state programs. Whether providers had a private practice or were employed through a nonprofit health organization, in both cases, low rates of reimbursement were seen to be a serious threat to being able to do "business" on a sustainable basis. Reimbursement was also discussed as an issue relative to providers having the appropriate amount of time with patients when prevention and education are the best options. Allowing for that time, valuing it as a reimbursable activity and allowing for the correct "coding" of the activity are all necessary to making the system function more rationally.
- ***Payment for the "right" care*** --- As much as there was concern expressed about adequate reimbursement there was also concern about reimbursement for providing the best care, often defined as being able to spend enough time with patients, or having "education" valued as a treatment.
- ***Access to care*** --- The system needs to provide better and more comprehensive access to primary preventive care and end of life care. This is both economically and clinically prudent. It was generally accepted that this included mental health services and complementary care as important components of health care. Personal stories from practitioners illustrated their concern that the lack of insurance or high cost of care was deterring significant numbers of people from accessing the most effective care at the earliest opportunity. All too often, providers see people at a later and more expensive stage in their need for care. Providers understood that there have to be choices in a system for it to remain financially viable and that expensive technologies and drugs many not be the best practice in all cases.
- ***Quality of care*** --- Quality of care permeated the discussion largely in how other issues might threaten it. Some of these threats included the lack of integration in the system, the increasing administrative burdens that diminished practitioner time with patients, and lack of adequate reimbursement that set up situations where business decisions were at odds with clinical decisions (e.g., how much time could be spent with a patient). There was a common feeling that the system could be improved if it was designed to deliver the best care at the most appropriate time and place.

Providers were, for the most part very clear on the need for developing clear indicators to measure what we would have for a successful system to be in place. Some of those indicators that were commonly mention included:

- Everyone has access to health care and quality care is provided for all
- Number of crisis calls reduced, and care is delivered more to maintain health than fix problems
- Everyone has access to care and it is sustainable
- Providers are knocking on Vermont's door to be part of the care model and delivery system
- Individuals are educated and involved in designing and implementing their own care plans as they are able to
- Services are integrated all under one roof

Must haves and can't haves

Providers were quite prolific and varied when asked what a reformed system of health care must have in order for them to support it. The many ideas could be loosely grouped under five topics:

- An integrated system that would support the delivery of good and consistent care
- Access to care for all Vermonters
- Incentives to provide the best care at the right time with more emphasis on early intervention, prevention and education
- An unmediated relationship between provider and patient
- A financing mechanism and cost containment that made the system sustainable

Interestingly there was little call for more money for providers, though it is a significant concern voiced elsewhere.

In terms of what they could not support in a reformed system, the list was also quite extensive and varied. There was some interesting overlap with employers as they voiced objection to a system that would increase costs to them, which would impose mandates, which would have a larger bureaucracy and more administration and paperwork. Providers however also included a long list of concerns about possible reforms that would negatively affect the health of their patients. This included systems of rationing, care reviews by non-providers, certain people being excluded from access to care, or a centralization of care delivery.

Ideas about Cost and Reducing Cost

Providers were adamant that they understood that continually rising costs were unsustainable and did not necessarily produce better outcomes. They offered a series of ideas about the reasons for cost increases and suggestion for cost reductions.

- Regulations are a cost driver. Generally all regulating bodies were included in this statement: formal regulations from the state governing reporting and requirements especially for hospitals, to insurance and reporting "regulations" for reimbursement.
- While providers are not engaged in decisions that actively shift costs in the system they recognize that this is going on and will not stop until a great percent of the money is spent on actual reimbursement for direct services provided.
- Providing appropriate care in a timely fashion is a cost saver. Early care is always cheaper, and the system needs to be set up to reward delivery of preventive and wellness care at the same rate that they reward delivery of acute and chronic care services.
- If external evaluators are going to question or challenge care decisions in regard to reimbursement, then there must be a peer relationship between the provider and the agencies that do the evaluation, not a bureaucratic non-clinical face. Decisions for care (and reimbursement) should be based on clinical evidence, not whether a procedure or service appears on a list.
- Attention must be paid to external forces that impact costs in the system including advertising (e.g., pharmaceuticals) and promotion of things directly contradictory to healthy lifestyles (e.g., fast food, soda, etc. in schools, as well as in general), smoking, drinking, etc.

- Information technology has a role to play. Having one patient record allows for quicker, safer, more coordinated care.

Mixed responses and differences among providers

The discussion among providers raised a number of issues, some philosophical, some about system design, and some economic on which there was extensive conversation but no consensus. These areas of discussion are outlined below and raise a number of important questions for future consideration in the legislatures continued conversation with providers:

- Personal responsibility – There was some disagreement on how personal responsibility should be addressed. For some providers, unhealthy choices should be penalized as such choices are in the control of the individual. For others it was a much more complex issue trying to understand the genetic pre-disposition to conditions such as obesity along with the fact that advertising for fast foods and soda exceeds by many times the entire state public health, and nonprofit sector budgets for education on good nutrition and healthy living. How much reliance should be placed on "information" as an intervention? Where is the evidence that providing information changes behavior? What are all the assumptions that need to be tested?
- Health care as a right – Is health care a right for Vermonters? If it is, what qualifications will be imposed to define a Vermonter for residency purposes? There was general agreement that access to health care (all levels of care, not just emergency care) should be available to all people. The discussion did not lead to the idea that health care was a "right," though that was discussed. It was also pointed out that because of the nonprofit system in Vermont no one is denied some level of care at these health facilities.
- Rationing or restriction of care – While there was general agreement that not all the perceived needs of the public will be able to be met within the system, what to do about this was controversial. There was also agreement that the system currently rations certain types of care through economic criteria. How much care should/can be given within a system that has limits still needs to be answered?
- All providers discussed the major administrative burdens the system imposes on them. There was, however, little agreement on the extent of actual dollar savings there was in administrative reform. The concern centered more on the time it took away from their ability to be with patients. Within this there was no agreement on whether a "single payer" system would be more efficient or provide for real relief. There were articulate individuals who advocated for or against such a system, but as with the other groups, the discussion of "single payer" often raised more questions about what people actually meant by the term than provided clarity on what it could or could not do.
- Faith in scientific advance – All providers agreed that the practice of medicine in all fields had greatly changed even in the last decade. These changes have been significant in how and where care is delivered, what outcomes can be expected, and what the public expects health care to provide. The pace of scientific advance is unlikely to subside. The impact of those changes will continue to have a widespread influence on the system that provides care. It will cure or prevent some diseases; it will help people live longer, but develop more complex and multiple conditions later in life requiring care; it will be

costly in new areas as it reduces costs in others; it will challenge the current health delivery infrastructure.

- Recruitment and Retention of Practitioners -- There are many factors that play into decisions by providers as to where to practice. The issue was presented differently depending on where one was. In Rutland there was considerable concern voiced about immediate threats to recruiting and retaining providers in the area as they could earn so much more elsewhere. In St. Johnsbury, there was also concern expressed, but it was more associated with the struggles of rural areas in general and having enough critical mass to attract and hold good practitioners and to have the range necessary to support a good health network. There was also concern that debt from medical school was deterring new recruits to the system, especially those that would graduate and practice as general primary care physicians. The shortage of nurses in Vermont was acknowledged, but as much work and attention had been presented on that in other venues, it was not a large topic of conversation.

(C) MIXED DISCUSSION GROUPS

These groups were a mix of people who serve in governing roles for nonprofit health care organizations, as health care office administrators responsible for interfacing with the financial system, and social service workers who assist Vermonters in navigating the health care system. In the sessions in Chittenden County there were enough Social Service Providers so that a separate group was organized. In several locations the group had a significant number of participants from just one local institution, but in most there was a diverse mix of participants who were part of the health system but were participating in the discussion neither as an Employer nor as a Provider.

Key Issues found in most, if not all, conversations as common elements

- ***Cost*** --- The issue of cost is addressed on several different levels. The rising cost related to operations of health care institutions and organizations need to come into line with sustainable growth. Controlling cost means having reimbursement rates more in line with the actual cost of delivering services, and reducing regulation and reporting burdens that create cost centers not related to delivering care. More frequently with this group cost is addressed as a factor that should not be a deterrent to providing necessary care to individuals. There is great concern that economic conditions are increasingly impacting individual ability to access care when it is most needed. Health care should be available to all, regardless of ability to pay.
- ***The viability and sustainability of the health system*** --- There is a great deal of shared anxiety over what will happen to the current health system (the infrastructure of hospitals, free clinics, health centers, and other modes of delivery) in a reformed system. The terms "viable" and "sustainable" were used a number of times as outcome descriptors on which to evaluate reform activities. The complexity and fragmentation of the current system are seen as major problems that must be addressed. There is a desire for reforms that will simplify the system and a concern that reforms may have the opposite effect
- ***Local control and local presence of health institutions*** --- The current system of regional hospitals and the supporting infrastructure around them should be maintained. New networks of care should be built off the existing system and not compete with it. These networks should support a more integrated system of care that is centered in the community but links to state resources. The ability of local communities to have direct connections with the health institutions and be part of the decision making process within these organizations is an important value.
- **"*Be cautiously bold*"** --- The sentiment embodied in this phrase was also articulated often in the public meetings in the evening. Generally it expressed a recognition that the system need to be overhauled in a way that made it more integrated and unified in the state. Getting there should be a process of careful and strategic experimentation. Pilot major system reforms to test them rather than implement sweeping system changes that may compromise many of the positive attributes of the system that we now have.
- ***Better Care Management*** --- Care providers need to be able to do their job and help patients set up and manage their own care to their fullest ability. This means that "care" includes education. The design of a management system for care, the adequate payment for it, and the allowance for care providers to take the time and provide education in their interactions with patients are all necessary components of a reformed system.

- ***Public Education*** --- How we think about the health care system needs to be broadened. Public education, through public health efforts, needs to be connected to and integrated with what we think about when we envision a health system. This education has a dual focus: How to be healthy, and how to use the system in a way that provides best results.

Must haves and can't haves

In responding to the question about what a reformed health care system must have for members to support it there was much more emphasis on systems issues than in other groups. There was a strong emphasis on increasing access to the system for Vermonters, but also on insuring that inclusion of more people within the system was done in such a way that it would benefit the system (e.g., move the cost of providing more care from high cost delivery to lower more predictable cost delivery).

Caution was also stressed around making system changes in that those changes must be able to test and evaluate new programs before switching to them altogether. Along with this there must be a system of integration between the different parts of the system. That integration still needs to be balanced against local control and ownership of the health infrastructure (e.g., community hospitals).

Adequate financing was also described as necessary, and expressed as better reimbursement rates to allow for less cost shifting. The reformed system would also have to place more emphasis on primary care and prevention and insure access to all services (e.g., mental health, dental, etc.).

Similarly when asked what they would not support if it were proposed, the concerns were identified as increased levels of bureaucracy, imposed additional reporting or administrative requirements on health organizations or programs, or other regulations. They were also concerned that a new system should not continue as a piecemeal approach to care and should not exclude either groups of people or important areas of care (e.g., mental health). Change should be systemic and connected, not a "band aid."

Ideas about Access and Delivery of Health Care

This group thought about access from a different perspective. Social service providers work with Vermonters to address many issues including accessing health care. They think about populations as well as individuals. Other participants who served in a governing role on the board of a health care organization had the dual role of thinking about people accessing the system through the frame of the organization's mission, but also from the viewpoint of someone responsible for the fiscal health of the organization.

- Choice, or at least flexibility, is a good thing; people are not the same, nor are their health needs; people change over time and a health system (and therefore the insurance that allows people to use the system) needs to accommodate the differences for age groups and groups with specific needs.
- Dental, eye care, pharmaceuticals, complementary care (e.g., acupuncture, chiropractic), physical therapy all need to be available through the system in order for it to succeed in delivering quality care.

- Parity of coverage for mental health, substance abuse and developmental disabilities.
- Helping people live independently (much less expensive than institutions): including personal care assistance at home and home improvements (e.g., bathroom upgrades).
- Health care providers are rewarded and not penalized for longer visits – better listening. Stop the push for high numbers every day and provide longer visits to see the whole person. Look at linking reimbursement to outcomes, not to numbers.

Focus on Costs and Reducing Costs

- No loss of coverage for those who have existing insurance; be able to keep coverage beyond link to employment.
- Look at under-insured, not just non-insured and working poor. Many Vermonters have inadequate insurance coverage to allow them to get the care they need.
- Community rating has not harmed Vermont.
- Discounts for healthy lifestyles should be allowed as an incentive, but should be coordinated with other incentives and changes in the system that encourages and empowers people to do what they are able to do.
- Coordination of benefits and care needed.
- Cut down on paperwork, on bureaucracy and regulation. Move to standardize forms and paperwork, and streamline reporting. Let health organizations do what they do best and not have to support large administrative departments that do not appear to contribute to better health outcomes for the state.
- Provide payment codes for health care providers so they can get reimbursed for education around chronic illnesses (as with diabetes).
- Much more emphasis on education and outreach to Vermonters for planning for end of life care and options. More than living wills. Directly take on advancing options to avoid skyrocketing cost of treatments that do not lead to better outcomes.

Mixed Responses and Differences within Group

There were important discussions about some of the key topics, such as "universal access" that did not lead to any particular resolution. A number of key questions were raised.

- Universal access – disagreement as to whether it should be a direct outcome of the current reform process or as a goal of a long term effort of reform
- What does universal access mean? Does it mean that every health need should be fully addressed all the time for everyone? How comprehensive should it be? How do you set realistic limits?
- "Access" has a special, additional meaning for certain populations (e.g., mentally ill, persons with physical disabilities for whom mobility is difficult). Here the "universal access" theme includes: transportation; portable health care, forms that are not onerous; "taking health care to the people."
- "Personal responsibility" is an ambiguous and possibly controversial term. What responsibility is on the individual and what is on the system?

(D) LABOR

Representatives of organized labor have increasingly cited health care as one of the most contentious issues in negotiating contracts whether with public or private sector employers. Of all the stakeholder groups, this group had the most in common with the tone of the evening programs. They expressed a clear and strong message that the need for change is urgent.

Labor representatives are not evenly distributed throughout the state, so the original design was to host two focused conversations with representatives. Only one was organized and held in Barre. Enough interest was generated in this conversation that plans were made to host additional forums with legislators beyond this initial process.

Key Issues found in most, if not all, conversations as common elements

- ***There is a crisis*** --- The crisis in health care is spilling over into other areas and creating problems for businesses, worker and communities. There is an urgent need for a significant overhaul of the system.
- ***Health care should be available and affordable to all ---*** A health system that is not providing universal care is not functioning well. The best interests for people and society are met when everyone gets the care that they need. That care should not be out of reach for any member of society.
- ***Everyone should pay and play*** --- If employers are going to continue to provide health insurance, then all employers should have to provide it. Not offering health insurance should not be a competitive advantage for a business. Employers should pay their fair share toward health benefits for workers, and workers should contribute fairly. As appropriate workers should be able to negotiate for increased benefits rather than always negotiating down.
- ***Health care should focus on the individual*** --- People, not insurance companies should be able to choose their primary care provider. Prevention should play a major role in delivering care and people working with the system to stay well.
- ***Plans should be Comprehensive*** --- Plans must incorporate total health coverage, including pharmacy plans. They should include a real focus on education, especially around prevention and chronic care.
- ***Health care should be decoupled from employment*** --- This is the only way to decouple health care from the bargaining table. It obscures all other issues.
- ***A Single Payer System*** --- Having a system with one payer for services that decouples providing health insurance from your place of work would actually be an economic stimulus, creating the potential for more jobs not less.

How do you measure success in a reformed system?

There was a great deal of discussion about what a successful system would look like. Some of the indicators that would demonstrate that a system was working well included:

- That there is a system of measures for success that are reported publicly
- There is a feeling of ownership by individuals in the system and in their own health
- Everyone is covered and has reasonable access
- The economy is healthier (and we can measure the connection between a reformed system and economic growth)

- There is a level playing field, all health care is paid for through a common system so that there really is equal access to the same care
- It costs less to provide care because people are healthier

Must haves and can't haves

For these participants a successfully reformed system would need to include the ability to chose a primary care provider, but should include limits that guide patients to the right provider type for the right type or care -- it should be a "smart" system. Mental health parity is achieved and education is a constant component in keeping people using the system well. It would cover all Vermonters, with employers and workers paying fair shares, in a streamlined administrative (single payer) system. Retirees would not see their benefits degrade.

What would not be acceptable would be a set of plans with high deductibles and high co-pays, with health savings accounts. Restricting choice, limiting types of care are not acceptable and allowing cost shifting to continue will only diminish the effectiveness of the system

Public education for public acceptance

Once a plan is set in place, this group emphasized the need for a broad-based public education effort. A reformed system will need to be brought into being through wide-ranging conversations and education efforts. Many groups will need to be enlisted to assist in this, and unions represent one of the groups that can reach a large number of Vermonters.

III. The "Drivers" of Health Care Reform

The legislature identified and explained what it saw as four key drivers of the need for health care reform in 2005. The Snelling Center used this base to develop public education materials including the guiding questions used to focus the small group and larger public conversations about health care reform: Access, Cost, Financing, and Quality.

Like most aspects of the health care reform discussion, the understanding and formulation of the drivers reminds one of the Buddhist parable of the Blind Men and the Elephant; depending on what perspective you bring or what part of it you grasp you will come away with a distinct and different picture of the whole. In the following section we attempt to identify some of the common agreements and distinctions in how participants in these conversations viewed the drivers. For many legislators and others this will not be new knowledge. These conversations demonstrate, however, what some of the differences are that need to be bridged and addressed in any proposal. In the effort to move reform ahead, it is just as important to consider how it is taken forward as it is what is taken forward in efforts to improve Vermont's health care system.

In any reform process that moves ahead, these contradictions must be addressed in order to bring the largest group of people forward to support system reform. Ungrounded assumptions must be shown to be without basis, and even then people may not be willing to let go of them. The process of public education and conversation must continue and is essential to the outcome.

In exploring these cross cutting themes we have drawn from all of the conversations and comments that have been received as part of the engagement process. This final section is not meant to be a summary, but rather another lens through which to see at least in part, both the diversity of discussion and the common points of agreement.

ACCESS

There was common agreement on the goal of providing all Vermonters with access to quality health care. Achieving this goal is a clear and measurable outcome.

There was less agreement on:

- Whether this is an immediate goal or the long term outcome of a reformed system
- Whether access meant equal access, or whether a tiered system of access to different levels of care would be fair and achievable
- Whether access was simply having a choice of health insurance or a more structured system of entry to the system
- If we have universal access, who is in the "universe?" How do we define a Vermonter in terms of access to our health care services?

Access also had broader connotations for some that is important to consider. Access was tied in some cases to the current system of community based hospitals and health centers. There was a strong consensus that this system be maintained, and that community "ownership" of local delivery systems be strengthened.

Access for some constituencies can also mean the physical ability to get to a point of care, something that is not easily available to all Vermonters.

Access for many is tied to choice, both choices of the "plans" that guide and help pay for care one receives and choice in a primary care provider (and possibly in the choice of all providers). In more rural areas that choice may be constrained, as the network does not support a particular type of service or practitioner in the region.

Access means having an integrated system so that the appropriate point of entry to the system is evident and welcoming, guiding patients to the best source of care, and the least expensive.

Finally, access has to be seen in light of knowledge and education. A constant theme emerged in promoting a more educated, informed and engaged citizenry in understanding how to lead healthier lives and how to make use of the health system we have most appropriately.

COST

Cost is clearly a factor that is primarily defined from one's position. For the State, it is the unrelenting rise of costs for providing Medicaid services to Vermonters. For providers and health organizations, it is the cost of accepting reimbursement from the State for services provided under Medicaid that do not come anywhere near paying for the service. For employers it is both the unpredictable and steadily increasing cost of premiums to provide health benefits for employees. For some social service providers it is the increasing costs being borne directly by citizens who come to them for aid, who are asked to shoulder an increasing financial burden to buy pharmaceuticals, or co-pays for health services. For collective bargaining units it is the increasing tension in negotiations over workers being asked to increasingly share more, or all, of the burden for paying for health care, generally at the expense of wage increases.

Costs are something:

- To be kept down
- That should not interfere with people getting the care they need
- Caused by too much regulation, bureaucratic inefficiency, and a disjointed system
- That are driven by
    - corporate greed (e.g., pharmaceutical companies)
    - not enough competition from the private sector
    - too much reliance on technology
    - not enough incentive to develop more efficient and effective drugs and technology
    - too many payers or not enough payers
    - lazy irresponsible people living unhealthy lifestyles
    - too much advertising and access to unhealthy food, tobacco and alcohol
    - too many people getting health care without contributing to the cost
    - too many people not having health insurance and not getting care when they need it

- Driven by a litigious society that forces practitioners to practice defensive medicine and pay high malpractice insurance rates
- Too much care being provided in inappropriate settings (e.g., emergency rooms), with preventable illnesses become chronic illnesses, and chronic illnesses resulting in acute conditions before they are treated, all at a much higher cost to the system
- That increase for some through a cost shift because not everyone is paying their fair share (employers, individuals, the State, the Federal Government)
- That providers tied to the need to constrain direct marketing of drugs to individual consumers. Other individuals at the open evening programs echoed this. For providers a great deal of time is wasted in addressing the questions and requests of patients who are asking for something based on advertising claims.

FINANCING

"How do we pay and who pays and what do we pay for anyways?"

While financing is a driver for health care reform, it is also a factor that is driven by costs. The finance system is constantly trying to catch up to the cost curve in health care. In most cases it is significantly lagging behind.[9] Much of the discussion reinforced the understanding that reforming financing mechanisms needed to closely parallel efforts to restrain cost increases.

Some of the areas that most people had in common were:

- Everyone should have access to the system and everyone should contribute financially.
- There should be an equitable formula that allowed people and institutions to contribute appropriately, and that contributions should not constrain individuals from seeking the care they need at the most appropriate time and place.
- The mechanisms of financing should be simple. Administrative systems, paperwork, documentation and reporting should be accurate and sufficient but not burdensome.
- Cost shifting should end
- Employers should pay equally and not be at a competitive disadvantage with other employers who do not pay into the system.
- Community rating has not harmed Vermont
- Some flexibility should be built into the system to reward and incentify healthy lifestyles

While much of the financing discussion focused on governmental systems (Medicare and Medicaid provide financing for a large portion of health costs in Vermont), an emerging conversation among employers (who pay through private insurance) was whether and to what extent the provision of health insurance should remain tied to one's employment. Organized labor and other groups and individuals also raised this as well. In all of the conversations where this issue was discussed no one argued for keeping the system (as a whole) the way it is today.

Central to the financing system as it exists is the ability of employers and individual workers to continue to pay for the increasing costs for private insurance (either directly or through a self-

[9] http://www.leg.state.vt.us/jfo/Healthcare/Health%20Care%20Finance.pdf

insured model) that helps to subsidize the underpayment for Medicaid and Medicare. Most participants were concerned that the current system of financing was unsustainable if not already in crisis.

Notably in the discussions with Employers as the issue of decoupling insurance from employment was brought up, a number of the participants took note that they had not considered that this was even a possibility, so ingrained is the employer based health financing system in society today. While some were quick to point out the fact that there were a number of legal and regulatory issues (most notably ERISA) that were impediments to moving in this direction, and some others (mostly in the evening programs and some written comments) disparagingly declared that if the alternative was a government run system like Medicaid, businesses would be worse off. We found that individuals holding this and other polarized positions tended to become more open to considering new information and ideas in the structured conversations, where the discussion among peers got beyond the mere mention of the issue.

QUALITY

Participants praised the level and quality of care they received or saw being delivered in the health system in Vermont. They were protective of the aspects of the system that they believed responsible for that success, most notably the community based nonprofit hospitals around the state. Surprisingly, though everyone supported high quality standards for health care in Vermont, the discussions about quality always appeared to reorient themselves around the concerns of access, cost and financing which were seen as the major impediments to continuing improvements in the quality of the health system in Vermont being achieved.

Vermont's hospitals, practitioners and other institutions have been engaged in a wide range of activities that have been publicly noted in improving quality outcomes. These have been led in part by the hospital association[10] and the Vermont Program for Quality in Health Care.[11] Various reporting mechanisms are in place. There appears to be high confidence in practitioners and institutions in provided for good quality outcomes.

Beyond institutional quality concerns, there are key concerns in non-institutional areas including individual choices and healthy lifestyles and the external forces that influence them. The role of the individual in achieving quality health outcomes for Vermont was an extensive and diverse conversation. There was common agreement that:

- Individuals play an important role in their health and wellness care;
- There is much more to be done to educate and empower individuals to participate to the best of their ability in activities and choices that will improve health and care outcomes;
- There are a number of external influences that contribute to negative individual behaviors and choices;
- The system needs to incorporate and embrace education and involvement of individuals more fully in the health system and their own wellness promotion and health care.

[10] http://www.vahhs.org
[11] http://www.vpqhc.org/

Some final thoughts on

Moving Forward

From the beginning this process has been one of engaging the public in the on-going conversation on health care reform. Unlike processes that preceded this effort (see list referenced from the introduction) it was not a "study," a "research" exercise or even an opinion poll. The desired outcome was to have an educational exchange and involve a wider segment of the public. It was not about new "solutions." The process was designed to broaden the perspective of the legislators who participated and open doors for Vermonters who had not been able to be engaged directly in the policy process in Montpelier in the first six months of 2005. The process design assumed that Vermonters, broadly, and in specific sets of stakeholders, were willing and capable of learning together while grappling with complex issues.

During the month that the legislative committees attended the six sets of conversations and visited different communities in Vermont there was a broad and deeper conversation about what the legislature had learned, the decisions that had been made and what the public was thinking. The completion of this process marks one more step towards a more engaged public and deeper conversations in Vermont on understanding where we are, what resources we have, and what choices we have to make to ensure that all citizens can enjoy the benefits of a continuously improving health care system.

What is the value of a conversation? Why should people be engaged and think together about the issues that affect all of us? Many Vermonters answer that every town meeting day. For others it is answered in the weekly engagements we have serving on select boards, school boards, committees and governing boards of community organization, or as volunteers with one of the several thousand nonprofit service organizations in the state. A process of constant and growing public engagement through conversations on this issue is essential if progress is to be made and sustained in the years ahead.

As the legislature and the administration move ahead to bring specific and substantive proposals to the table for further consideration, those proposals can be assessed against the key issues and questions identified in this process. These conversations provide a checklist of ideas, concerns, questions, assumptions and contradictions that should be addressed to help move proposals past biases and tightly held positions that prevent effective action.

Reform of Vermont's health system is not a short-term endeavor. Plans need to present a clear and well-articulated framework that will continue to engage Vermonters in the process of formulating the more specific changes needed to meet the goals of having a sustainable high quality health system serving all Vermonters. Vermonters continue to show that they care, desire, and have the ability to be engaged in addressing the complex policy issues that affect their lives.

APPENDICES

I. Legislators and staff involved in the conversation

II. Documentation of the Conversations

III. The Process of Public Engagement

IV. Stakeholder Focused / Structured Conversations

V. Sample results from continuing forums: 11/10 Woodstock community forum sponsored by the Ottauquechee Health Foundation

VI. Information Resources for a conversation on healthcare reform

APPENDIX I

Legislators and Staff involved in the Conversations

VERMONT HOUSE COMMITTEE ON HEALTH CARE
Representative Tracy of Burlington, *Chair*
Representative Severance of Colchester, *Vice-Chair*
Representative Ancel of Calais
Representative Baker of West Rutland
Representative Chen of Mendon
Representative Keogh of Burlington
Representative Leriche of Hardwick
Representative Louras of Rutland City
Representative Maier of Middlebury
Representative McFaun of Barre Town
Representative Milkey of Brattleboro

VERMONT SENATE COMMITTEE ON HEALTH & WELFARE
Senator Leddy of Chittenden District, *Chair*
Senator White of Windham District, *Vice-Chair*
Senator Flanagan of Chittenden District
Senator Kittell of Franklin District
Senator Lyons of Chittenden District
Senator Mullin of Rutland District

LEGISLATIVE STAFF
Rachel Levin, Jill Krowinski, Andrew Savage

THE SNELLING CENTER FOR GOVERNMENT
Staff at the Snelling Center who designed and managed this process include:
Jan Eastman, President
Glenn McRae, Director, Public Policy Programs
Colleen Oettinger, Facilities Manager
Katelyn Ritchie, Administrative Assistant
Russell Mills, Graduate Assistance

In addition, four facilitators were engaged to assist with the facilitated conversations:
Heidi Klein, Merryn Rutledge, Sharon Behar and Sue McCormack

APPENDIX II

Documentation of the Conversations

As part of its contract with the legislature The Snelling Center has compiled and submitted extensive documentation of this process of engagement. These resources available both at the legislature and at the Snelling Center include:

- Data base of all members of the public attending the Lunches and Evening Public Forums
- Data base of all individuals who were invited to the Focused conversations in the afternoons in the different categories, and all those who accepted those invitations
- Notes taken and compiled by Snelling Center Staff for:
    - Some Lunch sessions
    - All evening sessions public speaking
    - Notes taken from the evening kiosks – cards and flip charts
    - Notes taken by facilitators at the focused conversations as part of flip chart documentation of the conversations
    - Materials that were provided by organizations on several of the days and requested to be provided to the legislature as resources
    - A compilation of emails and other correspondence to the legislature based on this engagement process
    - Notes from a public forum on November 15th hosted by the Ottaquechee Health Foundation in Woodstock that utilized materials from the forums as the basis for their discussions

- Recordings of each of the Focused Group Conversations from all six sites (on CD)
- The Facilitator's Guide to Focused Conversations on health care reform
- A legislator's guide to hosting a focused conversation on health care reform
- A compilation of print, video and audio media reports on the forums

APPENDIX III

The Process for Public Engagement

The Snelling Center for Government[12] developed a process of civic engagement on expanding the conversation on health care reform to the Vermont citizenry based on several directives from the Joint Committee on Health Care. The Snelling Center was contracted to plan, conduct and evaluate the "public engagement process" for health care reform required by Sec. 277e of Act 71 of the 2005 Legislative Session. That law provides: "*In recognition of the importance of public engagement, the House Committee on Health Care and the Senate Committee on Health and Welfare [the Joint Committee] shall have six public hearings during the interim of the 2005 legislative session to solicit input from citizens, employers, hospitals, health care professionals, insurers, other stakeholders and interested parties about health care reform*."

Through its work with Coalition 21, The Snelling Center had already been facilitating a broad-based coalition of stakeholders who were grappling with the issues connected to transforming the health care systems of Vermont independent of the legislature. Coalition 21[13] had produced a set of principles[14] to guide and evaluate future health care reform efforts in January 2005. The House Committee on Health Care had adopted these principles to guide their deliberations, and they were later incorporated into H.524. The Center had developed and operated numerous public conversations on key policy issues in Vermont since its inception in 1993.

In designing this process the legislature requested that, whatever process was implemented, it would advance a very real dialogue with the public offering legislators a chance to engage with Vermonter's who ordinarily would not have been in Montpelier and therefore heard by the legislature during its regular deliberations. In addition, the legislature requested that the process be an opportunity to share the learning that it did during the Session and engage people in a conversation about why they reached the conclusions that they did. Seventeen legislators are members of the Joint Committee. Their work on this issue would fundamentally change the lives of all Vermonters in regard to health care and they saw this as an opportunity to be able to bring their discussion out beyond the committee room. The point was to engage more broadly the Vermonters directly rather than through the interest group representatives in Montpelier or just their own constituencies in their legislative districts.

The Snelling Center worked to design a process that was based on the principle of listening for legislators and dialogue for the citizenry they were reaching out to. The legislation that authorized this activity specified conducting six hearings in different regions of the state. Working within this limitation the process was designed to host an effort in Springfield, Rutland, Lyndonville/St. Johnsbury, Bennington, Chittenden County and Barre. The effort was not conceived to be totally representative of all Vermont, but to reach enough diversity of the Vermont citizenry that the conversations and contributions from these engagements would be representative of Vermont. The Snelling Center recommended discarding the notion of a

[12] http://www.snellingcenter.org/
[13] http://www.snellingcenter.org/coalition21/
[14] http://www.snellingcenter.org/coalition21/principles.html

traditional set of hearings and replacing that with a multifaceted set of engagements designed to give participating committee members the full benefit of citizen opinion, thought and ideas.

The six days of engagement were each set up to have four distinct opportunities for engagement. In each of the communities The Snelling Center worked with local community leaders and groups to have a local luncheon organized with local community members organizing and inviting participants.[15] After a welcome from the local organizer, Representative Tracy and Senator Leddy would provide brief opening comments providing an overview of the process for the entire day, and explained that lunch was their opportunity to talk about their concerns and hopes with different members of the Joint Committee who were sitting at each of the tables. Conversations would go on for ninety plus minutes, and sometimes more. Almost 150 local leaders and concerned citizens from the six regions joined these lunch conversations. For committee members it was an opportunity to listen to general and specific concerns and to get a sense of issues that might be more local. It was also an opportunity for legislators, whose constituency was from a different part of the state, to have a dialogue with different constituencies and interest groups representing a more diverse set of viewpoints than may be typically found in their home district.

Legislators then moved to a set of focused conversations organized and facilitated directly by The Snelling Center. A professional facilitator, Heidi Klein[16] of Essex Jct., designed this process. It was organized as a structured conversation to be carried out by specific groups while legislators observed, but did not participate. The conversation was organized around ten questions (see Appendix IV), that were designed to guide participants out of the realm of complaint and ideology, and into a exchange over their hopes and fears for health care reform (including the option of no reform) speaking from their particular vantage point. These included groups organized around the role of:

- Employers, in which private, public and nonprofit sectors were represented;
- Health service providers, including MD's, RN's, dentists, optometrists, chiropractors, mental health providers and others, including some medical and nursing students;
- Governing Board members of a health care organization;
- Administrators of a health care organization or private health practice;
- Social Service providers who helped individuals access and navigate health services;
- Representatives of organized labor.

In this fish bowl environment legislators were charged with a long listening task. A number of the participants from the legislature (this included at times members of the local delegation as well as committee members) noted that "so much listening" was a difficult exercise for them, but in the same breathe also noted the high value of being able to follow a thread of a focused

[15] Springfield – Rotary Club and Springfield Regional Development Corporation
Rutland – Rutland Region Chamber of Commerce
Bennington – Bennington Area Chamber of Commerce
St. Johnsbury – Rotary Club and friends
Essex – League of Women Voters
Barre – Central Vermont Chamber of Commerce

[16] Ms. Klein's experience includes professional employment with the Risk Communication Center at Rutgers University, The Green Mountain Institute and the Vermont Department of Health, as well as numerous private clients.

conversation from beginning to end without their own ideas and prejudices directly being inserted into the conversation.

Member of the Joint Committee came away from this listening opportunity, with a brief break for dinner, to the final set of engagements. This was composed as part of an evening program, open to full public participation, advertised in local papers and through multiple networks, and hosted in public facilities. While many people came expecting it to simply be another "hearing" forum, it was actually a two part process, again designed to have committee members put in a position to be able to explain how they learned about the problems and issues with the current health care system, and to share how that learning took them in certain directions to propose a new structure for moving health care system reform ahead (as embodied in H.524). After people convened for the evening, were greeted by a local civic figure, Representative Tracy and Senator Leddy, would introduce the committee members and other legislators in the audience, and then explain the somewhat different format for the evening. The attending public was invited to mingle with committee members who would be stationed at five kiosk displays in the room each one designed to share a segment of information on the learning that the committee engaged in over the course of the last legislative session. The kiosks were built around the issues of Access, Cost, Financing, Quality, and the principles for reform adopted by the legislature. For up to one hour, citizens would read information on the kiosk posters or handouts available at the tables (See Appendix VI) for the information that was shared), discuss this with committee members, write comments on flip charts by each table or put their comments on cards made available at each table. At an appropriate time, the participants were reconvened as a large group and Senator Leddy and Representative Tracy then opened the floor for general comments from the attending public, which went on for 60-90 minutes, before the day's activity was concluded.

Understanding that the process could not be taken to every community, or even every region of the state, Legislative staff established a web page to explain the process and display the information that was being used to organize the conversations. People were encouraged to send in comments by email, fax or mail in addition to attending the sessions. These tools for continued public comment remain open. In addition The Snelling Center developed and is making available through legislative staff, a guide for individual legislators or other groups to host facilitated conversations that will parallel those facilitated by The Snelling Center so that ideas, thoughts and information collected from ongoing conversations will parallel that already collected.

With approximately 800 Vermonters participating over the six days of programs, the general assessment is that the process was successful in expanding and deepening the conversation on health care reform for the committees. Their work as active listeners, in multiple formats and in diverse communities, took them outside their comfort zones in some cases, but expanded the opportunities to create a forum for listening and dialogue not possible during the regular course of the legislative session. The legislative intent of the activity was to "solicit input from citizens, employers, hospitals, health care professionals, insurers, other stakeholders and interested parties about health care reform." The unwritten intent was to further enable committee members to better understand the context of their deliberations in an organized fashion – that context being how the results of their deliberations would affect and impact the lives of Vermonters who after the session will continue to play their roles as employers, health providers, administrators and

governing members of health organizations, as social service workers, labor negotiators, or just as citizens who need or will need health services.

Legislators have had (and continue to have) many important conversations, and have received many comments from constituents and Vermonters from around the state on this topic. The Center's assessment is that while this is true, little is done to document this and when it happens it is not a shared experience, for the most part, with their colleagues. Organized engagement, such as that designed by The Snelling Center, provides that organization and documentation in a context that creates a shared experience for legislators who will continue to work together and between legislators and a wider group of Vermonters. Engagement is as much about education as it is about communication. Legislators participated directly in this education process and were able to observe Vermonters directly engage with each other in a group learning experience. People willing to talk together, is an important step in growing civic engagement. People willing to learn together, is a big step toward advancing a real Vermont public policy environment.

APPENDIX IV

Stakeholder Focused / Structured Conversations

Goal: To identify key parameters, and the underlying values they represent, that are needed in a health care system reform/proposal in order for it to be acceptable to different key stakeholder groups (NOT design ideas, funding mechanisms, solutions)

Process: *These ten structured questions were used by all facilitators to advance the structured conversations in the afternoon, and a subset of these questions were used in the evening programs to advance public conversations from the same framework.*

Questions:

1. **What are your primary concerns/responsibilities as an _____ (employer, provider, health organization/institution board member)?** This first question is to make sure that your _____ hat is on and securely fastened. Please help me to understand your primary concerns/objectives/responsibilities as an _____.

2. Again, I want you to write down **up to 3 items** in response to the next question.

When you think of health care reform what immediately comes to mind?

Today's discussion is going to focus on the intersection of these two lists—your primary responsibilities and priorities as _____(employer, provider, health organization/institution board member, organized labor, social service provider) and health care system reform.

As you know there has been a lot of discussion and attention to our current health care system. I want to share with you the major themes that have previously been identified in discussing health care reform in the state of Vermont.

- Cost
- Access (to health insurance)
- Quality
- Fragmented health care system (health care professionals, payers, patients)
- Inequity in financing

3. Looking at the list we just generated, **would you like to add anything to the reasons to consider health care system reform in Vermont?**

COMPARE STATEMENTS FROM QUESTION #1 AND QUESTION #2 WITH 5 REASONS

4. If there are to be changes in our health care system, **what needs to be maintained in order for you to feel confident that a new system will meet your needs as a _____?**

5. **If the system is to change, what might work better for you than the current health care system?**

6. **What are the assurances you would need to support any proposed changes in our statewide health care system**?

We often talk about the strength and quality of our health care system in terms of the number of people insured, the cost of insurance, the services offered. I want us to the measures of success **you** would use in saying a new health care system met your needs and addressed your responsibilities as an _____.

7. **If you had to draft a list of measures of success of a health care system in meeting your needs and concerns what would be on that list? How might we measure success?**

8. For this next question, I want you to write down up to 3 responses to a statement where you will be asked to fill in the blanks. Here is the statement**: If a health care system DOES NOT INCLUDE_____ I would not be able to support it because_____.** Meaning, any system must have it in order for it to be acceptable (must have). Please complete this statement.

9. For this next question, again a fill in the blanks. Here is the statement. **If a health care system INCLUDES _____ I would not be able to support it because_____.** Meaning, there is something that may be included that would be exceptionally objectionable (can't have). Please complete this statement.

10. **Suppose you had only 30 seconds with your state representative to talk about Vermont's health care system, what would you emphasize?**

APPENDIX V

The Future of Health Care in Vermont

Thursday, November 10, 2005 Town Hall, Woodstock, Vermont

A public forum sponsored by
Ottauquechee Health Foundation

Responses to Questions

1. **If there are to be changes in our health care system, what needs to be <u>maintained</u> in order for you to feel confident that a new system will meet your needs?**

   - Privacy, even with technological advances
   - Easy access
   - Choice—the ability to choose your own provider
   - Accountability
   - Incentives that drive current advances in technology
   - Innovation
   - Lack of rationing (e.g. Oregon)
   - Advanced directives

2. **If the system is to change, what might <u>work better</u> for you?**
   - Access to affordable, non-employer based health insurance
   - More information: How do costs break out between public/private financed parts of the system?
   - Try an experiment (randomize) to test theories
   - Universality over comprehensiveness
   - Connectivity/communication between parts of the system (e prescription) between parts of the system
   - Check whether standards of care are being adhered to (failure is very expensive)
   - Universality
   - Figure priorities: life support v. prevention
   - Personal ownership of each person's wellness, not the system
   - Eliminate the cost shift (might reduce premium costs 20-30%)
   - Reduce administrative overhead

3. **What are the <u>assurances</u> you would need to support any proposed changes in our statewide health care system?**
   - Still able to go to DHMC (a provider in another state)
   - All possible being done to fight fraud, waste & abuse
   - Costs will be contained
   - System won't be like the VA health care system

4. **How might you propose we <u>measure success</u>? If you had to draft a list of measures of success of a health care system in meeting your needs and concerns what would be on that list?**

- Track OUTCOMES, like: infant mortality, life expectancy, absence of diseases; publish results, if possible by doctor and by hospital
- No waiting
- Those who can't afford, especially children, are covered
- Bankruptcies due to health costs decline
- Quality care delivered: specific, appropriate service; not generalized
- Find out outcomes for particular procedures, comprehensively
- Amelioration of cost increases
- Evidence of healthier lifestyles (e.g. obesity)
- Responsiveness: health care at pace with needs
- Information/Education: people are informed
- People are accountable
- Average time of doctor visit increases (e.g. from 2.8 min. to 5 min.)
- Decrease in unnecessary hospitalization (fewer crisis situations)
- Reduction in use of emergency room for primary care
- Away from "patient" mentality: More realistic expectation of heath care needs
- Increase quality-adjusted life years
- Patient satisfaction

5. **If a health care system DOES NOT INCLUDE_____A_____ I would not be able to support it because_____B_____. Meaning, any system must have it in order for it to be acceptable**.

A	B
• Access for everyone	• Fairness, equity
• Affordability for both individual, state	• Won't be able to pay for it
• Patients accountable for cost, care	• Won't control costs, won't follow advice, won't become educated
• Accountability of provider	• Excessive waste
• Preventive view of medicine	• In big trouble
• Addressing life styles at schools and in the whole community	• Health will continue to deteriorate
• Triage	• Some people unable to make their own decisions about health care

Your responses will be forwarded to the Governor and Legislature in Montpelier for inclusion in their consideration of the future of health care in Vermont. Please return by ***November 17, 2005*** *to:*

Ottauquechee Health Foundation
P. O. Box 784, Woodstock, VT 05091

APPENDIX VI

Information resources for a conversation on health care reform

(offered at all public sessions and available on the legislative health care web site)

Health Care Reform
The Vermont Legislature - Public Forums
Sponsored by the Joint Legislative Committees

House Committee on Health Care (Chair: Rep. John Tracy)
Senate Committee on Health and Welfare (Chair: Sen. James Leddy)

The history and current work of the Vermont Legislature on Health Care Reform is available at http://www.leg.state.vt.us/healthcare/
This site will also link you to updates and events associated with the work of the Legislature.
To provide further contributions to the conversation on health care reform contact your local legislator, and send your thoughts to:

healthcareforums@leg.state.vt.us
Mail/fax: Health Care Forums/Vermont Legislature **Speaker's Office, 115 State St., Drawer 33** **Montpelier, VT 05633 [FAX 802-828-2220]**

Principles of Health Care Reform in Vermont

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.

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

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

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

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

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 make informed use of all health care services throughout their lives.

The "drivers" behind health care reform efforts are often summarized as:

Cost - Rising costs and how to control costs.

Access - How can we achieve universal access so all Vermonters have equitable access to care?

Quality - How to continually improve quality and prioritize quality improvements in the system based on our experience and what is feasible.

Equitable Financing - How do we pay for the health care system we all want? How do we share costs equitably? What system can we forge so that everyone contributes and shares the cost?

Questions that follow our consideration of these "drivers:"

If there are to be changes in our health care system, what needs to be maintained in order for you to feel confident that a new system will meet your needs?

If the system is to change, what might work better for you?

What are the assurances you would need to support any proposed changes in out statewide health care system?

How might you propose we measure success? If you had to draft a list of measures of success of a health care system <u>in meeting your needs and concerns</u> what would be on that list?

If a health care system DOES NOT INCLUDE_____ I would not be able to support it because_____. Meaning, any system must have it in order for it to be acceptable.

ACCESS TO HEALTH CARE

In 2001, 43000 Vermonters were uninsured; the number rose to approximately 71,000 in 2005—more than 10% of all Vermonters.

Projections increase the uninsured to 80,000 in 2010.

<u>The Problem is getting worse</u>

More than 60,000 Vermonters have no health insurance. Lack of insurance is associated with an increased rate of illness and a shorter life expectancy.

Premium cost increases have contributed to the growing rate of underinsurance, with more and more Vermonters purchasing high-deductible and less comprehensive plans.

The costs of health services provided to individuals who are unable to pay are shifted to others. Of the $2.1 billion charged by hospitals in 2005, $88 million was not collected as follows: $37 million in charity care and $51 million in bad debt.

<u>Who pays the cost of the uninsured or underinsured?</u>
The uninsured cover approximately 1/3 of the cost in out of pocket payment.
Higher premiums for those who have coverage pay another 1/3
Government assumes a larger role and funds approximately 1/3 though taxes

Those who bear the burden of this cost shift have an increasingly difficult time affording their own health care costs, including premiums.

- **Much like being uninsured, having inconsistent health insurance coverage limits access to care. People who go through periods in which they have no coverage are less likely to have a regular doctor and more likely to delay seeking care when they're sick.**
- **22 percent of the U.S. population experienced at least one spell without any health coverage over the two-year study period, in addition to the 9 percent who were uninsured for the full two years.**
- **Young adults, Hispanics, people with low levels of education, those who transition into and out of poverty, and those with private, nongroup insurance were most likely to have unstable coverage.**
-

Entrances and Exits: Health Insurance Churning, 1998–2000, Kathryn Klein, M.P.H., Sherry A. Glied, Ph.D., Danielle Ferry, M.S., The Commonwealth Fund, September 2005

Cost of the health care system in Vermont

From $1.7 billion in 1996 to $3.2 billion in 2004
(an 88% increase in 8 years)

Cost increases nearly $1 million a day, or $350 million a year to support our current health care system.

In 2005, the state of Vermont will spend an estimated $5,700.00 per capita on health care, more than any nation -- except the United States

itself -- when measured as a proportion of gross domestic product.

In 2003 Vermont's health care spending was 14.7 percent of the gross state product.

Health care costs have risen an average of 9-10 percent per year over the past 30-40 years, with the rate rising to 10-11 percent in more recent years.

These figures are well above the Consumer Price Index and exceed the state's capacity to pay for health care costs as measured against our gross state product.

For example, between 1996 and 2002, health care spending in Vermont rose 63 percent, while personal income rose 41 percent and gross state product rose 35 percent.

Over one-half of bankruptcies nationally are associated with high medical expenses. In approximately three-quarters of health-related bankruptcies, the patient had insurance.

FINANCING

Healthcare financing is accomplished through a patchwork of public programs, private sector employer-sponsored self-insurance, commercial insurance, and individual payers.

There are two fundamental inequities in the current insurance-based financing system:
(i) premiums are not based on ability to pay, and
(ii) deductibles and coinsurance place a financial burden on those with serious illness.

At any particular point in time, approximately 10 percent of the Vermonters generate approximately 70 percent of all health care spending.

Presently, there are 130,000 Vermonters enrolled in Medicaid, 90,000 in Medicare, and 150,000 in private sector employer-sponsored self-insured plans. Combined, it is projected that these individuals will account for nearly $2.3 billion of the $3.8 billion Vermont will spend on health care in 2006.

* In 2004, the costs of health care for 10.7 million Americans ***with insurance*** represented more than 25% of their earnings

* Employment based healthcare premiums are growing faster than wages.

Tax Dollars pay for much of Health Care Spending

- **Property taxes support health benefits for municipal and school system workers and teachers.**
- **Payroll taxes support Medicaid and Medicare.**
- **State Income taxes support state employee health benefits.**
- **State Income taxes also support a number of health programs through the Agency of Human Services.**
- **Federal Income taxes support federal employee health benefits and fund a variety of other federal health programs.**

QUALITY

The quality of health care services in Vermont is generally very good, especially through our network of community based hospitals.

There is still a need to improve quality, efficiency, and safety. Improvements in health care quality can result in improved health and reduced costs. The existing payment system does not tie reimbursement to improved health.

There are an unacceptable number of adverse events attributable to medical errors. According to the Institute of Medicine report entitled "To Err is Human: Building a Safer Health System," nationwide, the right care is given to the right person at the right time only about half the time.

- Our health care infrastructure and services tend to be "disease-focused" rather than "health-focused," resulting in missed opportunities for less costly and more effective forms of care.

- Medical errors are costly. They result in the loss of human lives and increase the costs of providing health care

- Poor quality [care] costs employers $1900-$2250 per covered employee each year. *(Midwest Business Group on Health)*

- 30% of all direct health care outlays today are the result of overuse, misuse, and waste.

- Only 55% of recommended care was actually delivered. *(RAND study published in NEJM)*

GOALS OF HEALTH CARE REFORM (H524)

Consistent with the adopted guidelines for reforming health care in Vermont, the general assembly adopts the following goals:

(1) Universal Access. Vermont policy will reflect that universal access to health care is a public good. By 2009, Vermont shall have an integrated health care system that provides all Vermonters, regardless of their age, employment, economic status, or their town of residency, with access to affordable, high quality health care that is financed in a fair and equitable manner.

(A) In order to reach this goal, the state shall begin by offering limited benefits and shall expand benefits over time after meeting specified benchmarks. A process will be developed to define the benefits, taking into consideration scientific evidence, available funds, and the values and priorities of Vermonters.

(B) The benchmarks shall measure the appropriateness and feasibility of a proposed expansion based on its ability to promote the following: long-term cost savings, increased access, improved quality and delivery, administrative simplification, fair and equitable financing, financial sustainability, and continuity of coverage.

(2) Cost Control. It is imperative that health care costs are brought under control. Likewise, it is essential that cost containment initiatives address both the financing of health care and also the delivery and quality of health services offered in Vermont. To ensure financial sustainability of Green Mountain Health, the state is committed to slowing the rate of growth of health care costs to seven percent or less by the year 2010. Strategies for containing costs shall include:
(A) global budgeting of and global payment to hospitals;
(B) tort reform;
(C) increased consumer access to health care price and quality information;
(D) promotion of self-care and healthy lifestyles;
(E) enhanced prescription drug initiatives;
(F) funding of the chronic care initiative;
(G) investments in health information technology;
(H) alignment of health care professional reimbursement with best practices and outcomes rather than utilization; and
(I) development of a long-term strategy for integrating the health care delivery system as well as a strategy for integrating health care policy, planning, and regulation within government.

(3) High Quality. Vermont's health delivery system must model continuous improvement of health care quality and safety. Vermonters must have the tools and resources necessary to make informed use of all health care services. Health care professionals and facilities should have incentives to provide the best and most appropriate care to Vermonters. The state should also do its part to improve quality and safety by coordinating health care policy, planning and regulation.

(4) Equitable Financing. The health care system in Vermont should be financed in a fair and equitable manner. All Vermonters should have access to health care; all Vermonters should contribute to its cost.

What did the 2005 Legislature propose through H.524?

The three basic elements of H.524 are:

- Every Vermonter should have a doctor.
- Every Vermont resident and Vermont business should contribute to the cost of health care.
- We need a long term approach to cost containment through integrated health care delivery systems, better information systems, and a focus on keeping Vermonters healthy.

As legislators studied the health care system and its challenges and strengths, they determined that universal access and cost containment are linked. You can't have one without the other. To contain health care costs Vermont must rethink its health care system so that it is a more integrated system, coordinated around maintaining the health of all Vermonters. In H.524 the design of this approach was called Green Mountain Health.

Access: As a first step, beginning July 2006, Green Mountain Health would provide primary and preventive health care coverage to all uninsured Vermonters who don't qualify for Medicaid. Upon meeting certain cost containment and performance benchmarks Green Mountain Health would expand to offer: primary and preventive health care coverage to all Vermonters in July 2007; hospital coverage to all Vermonters in October 2008; and a common benefit to all Vermonters in July 2009.

Cost Containment. Cost control initiatives address financing, delivery, and quality of health services. These cost containment measures include:

- More stringent control of budgets and payments to hospitals;
- Improving how we manage chronic illnesses like diabetes and heart disease;
- Consumer access to health care price and quality information;
- An information technology initiative to better coordinate patient and billing information and assess alternative methods of reimbursing for care in ways that align reimbursement with positive outcomes;
- Prescription drug initiatives that focus on more consumer information and oversight of the pharmacy benefit managers;
- Medical malpractice reform, including options for medical liability self-insurance, and what's called a "safe apology" by hospitals;
- Healthy lifestyles insurance discount under some circumstances;
- Expansion of primary care health centers and free clinics;

Financing. Financing for Green Mountain Health is based on the belief that everyone should have health care, and everyone should help pay for it. In the first year of Green Mountain Health, the "Health Effort Tax" would ensure that everyone contributes. Employers who spend at least 3% of payroll on health care *would pay nothing more*. Small employers with $50,000 in payroll who spend at least 1% on health care would pay nothing more; and employers not making a minimum contribution would pay 1% of their first $50,000 in payroll, and 3% on their remaining payroll, minus any health care spending.

H.524-Progress of Health Care Reform After the Veto by the Governor. Leaders in the House and Senate have adopted two approaches for the interim between 2005 and 2006 sessions. One focuses on analysis, the other on seeking input from Vermonters. In both arenas the legislature is seeking professional assistance that will move this process along in a constructive manner

Analysis
The Legislative Commission on Health Care Reform, chaired by Senator Leddy and Representative Tracy, has been established for the purpose of seeking information and analysis of questions that were raised during the health care debate. In particular H.524 directs the commission to contract for analysis of options for financing health care and an economic impact study of universal access to health care. The Commission may also make recommendations concerning aspects of health care reform measures in future legislative sessions.

The Commission on Health Care Reform is established for a period of four years. The Commission is made up of 8 legislative appointees and 2 gubernatorial appointees. The Commission may hire up to 3 staff members to implement its work.

The Commission has engaged the services of Dr. Ken Thorpe for analysis that would be helpful in making health care more affordable in Vermont. Dr. Thorpe is the Robert Woodruff Professor and Chair of the Department of Health Policy and Management in the Rollins School of Public Health in Atlanta, Georgia. He has held numerous teaching and consulting positions in health care and served as Deputy Assistant Secretary for Health Policy in the U.S. Department of Health and Human Services in the Clinton administration. He also consults for the National Coalition on Health Care Reform that includes Honorary Co-Chair President Bush. It is a coalition of business, labor, insurance, and health care organizations.

Public engagement
The legislature also authorized the Senate and House Committees on Health Care to hold public engagement sessions throughout Vermont over the course of the summer. The legislature has set up a contract with The Snelling Center for Government to organize and facilitate this process. Additionally, individual legislators are convening gatherings of constituents to present how we see the challenges, how the legislature proposed to change the system, and to seek guidance and feedback.

Information about this public engagement process is available through the legislature's website, HREF="http://www.leg.state.vt.us/healthcare/" MACROBUTTON HtmlResAnchor http://www.leg.state.vt.us/healthcare/ .