

REPORT TO THE
GENERAL ASSEMBLY

A Report on the Health Care Reform Financing Listening Sessions:

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by

The Agency of Administration

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SUMMARY OF REPORT: HEALTH CARE REFORM FINANCING LISTENING SESSIONS

The Agency of Administration engaged in public outreach to shape the development of the health care reform financing plans due to the Legislature in 2013. The public was invited to attend town meeting style listening sessions that provided a baseline level of knowledge to participants regarding the current health care system, health care reform, health care financing, and the State's financing. The Agency of Administration held these listening sessions in Brattleboro, Rutland, Burlington, and St. Johnsbury in the Winter of 2011-2012 and nearly 400 Vermonters attended.

After hearing background information, participants were asked to engage in two small group exercises. First, participants were asked to examine a list of 14 potential policy preferences focused broadly on equity, stability, and affordability that could shape health care reform financing and choose up to three preferred principles. Also, participants were asked to choose one least desired principle. Second, participants were asked to consider a mix of funding sources and express preferences for the sources that may be considered to fund universal health care in Vermont. Participants expressed their preference by allocating money into a range of potential funding sources.

The data gathered at the listening sessions revealed that participants preferred the administration to focus on equity, designing a system that is sufficient to pay for the health care of all Vermonters, requires that all Vermonters pay into the system, and takes into account ability to pay. Simultaneously, participants preferred that the financing plan provide incentives so that those making healthy choices and living in good health can pay less.

The data revealed a lack of uniformity regarding principles that ought to be deemphasized. The principle, that a health care system be “sensitive to interstate and international economic pressures for Vermont businesses” received more votes than any other; however, only 26% of participants selected to deemphasize the principle. Conversely, 74% of participants chose another principle to deemphasize. This may reflect a need to engage the business sector more or as a call to action to explain to the public the importance of maintaining and enhancing Vermont’s economic competitiveness through health care reform.

Next, participants expressed a preference for a broad range of funding sources, as each source received some votes, none received a majority of votes, and only one source received more than one-third of votes. Given this data, it is a reasonable inference that Vermonters may prefer a financing plan with a diverse and balanced mix of revenues. This inference is supported by the moderate preference for the principle that health care financing should be “balanced with diverse revenue sources for reliable, sufficient funding that capitalizes on federal funds available for health care.”

The two most popular funding source preferences were an income tax and consumption tax. A reasonable inference is that participants effectively connected their selection of principles and funding sources. Individuals emphasized principles that supported equity and healthy choices/good health, and an income tax and consumption tax mirror these choices. Accordingly, the most preferred principles and funding sources seem to be in some alignment.

The listening session exercises were not intended as a scientific survey. The exercises were designed to capture generally the sentiments of those Vermonters who chose to attend the sessions to learn more about health care reform and share their thoughts and preferences. The listening sessions were attended by a self-selecting group. Therefore, the data is not reflective of Vermonters

who did not attend or could not attend the sessions. Given these facts, the data within the report is not considered a complete analysis of the policy preferences of Vermonters. Overall, the data should be considered a useful guidepost to policymakers and one of many valuable aids in the formulation of the financing plans between now and January 15, 2013.

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Section I Statutory Charge

The General Assembly passed Act 48 of 2011, an act relating to a universal and unified health care system.¹ The law set in motion health care reform in Vermont. One milestone required by Act 48 was a proposal for financing plans. Specifically, Section 9 of Act 48 required the Secretary of Administration to recommend two plans for sustainable financing of the health care system to the relevant legislative committees by January 15, 2013.² Furthermore, Act 48 required the Secretary of Administration to seek public input prior to the formulation of these financing plans.³ Specifically, the Legislature directed the Secretary of Administration to focus on gathering two specific types of input from interested stakeholders before creating financing proposals.⁴ These inputs were the design of the health care financing plan generally and the perceived impact of specific funding sources. The Administration fulfilled this public input requirement through the development and execution of health care financing listening sessions held throughout Vermont during the winter of 2011-2012.

¹ See <http://www.leg.state.vt.us/DOCS/2012/ACTS/ACT048.PDF>

² Act 48 requires that the secretary of administration or designee recommend two plans for sustainable financing to the house committees on health care and on ways and means and the senate committees on health and welfare and on finance no later than January 15, 2013. One plan shall recommend the amounts and necessary mechanisms to finance any initiatives which must be implemented by January 1, 2014 in order to provide coverage to all Vermonters in the absence of a waiver from certain federal health care reform provisions established in Section 1332 of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as further amended (“Affordable Care Act”). The second plan shall recommend the amounts and necessary mechanisms to finance Green Mountain Care and any systems improvements needed to achieve a public-private universal health care system.

³ See Act 48 of 2011, §§9(c) and 9(d).

⁴ Ibid.

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Section II

Health Care Reform Financing Listening Sessions

This portion of the report consists of six sections, each addressing an aspect of the development and execution of the health care reform financing listening sessions.

2.1 Aims of the Listening Session

The aim of the health care financing listening sessions was to gather public input, approximately a year prior to the submission of the financing plans, that would assist the Administration in the development of the financing plans due to the Legislature by January 15, 2013. Accordingly, interested stakeholders would not be reacting to a set plan or proposal. Rather, they would engage in a dialogue and exercises designed to provide the Administration with specific, actionable policy preferences to consider while formulating health care reform financing proposals, focusing on the general design of the financing plan and specific funding sources. Agency of Administration staff and other executive branch staff began to turn these aims into a plan for public engagement during the Summer and Fall of 2011.

2.2 Development of the Listening Sessions⁵

The primary consideration in the design of the listening sessions was to create a process that engaged a broad group of interested stakeholders of varying knowledge levels and empower them to provide useful input. The Agency of Administration staff selected a format for these sessions familiar to nearly all Vermonters: the town meeting format. The town meeting format would draw upon the adeptness of Vermonters at engaging in a dialogue with each other and coming to express policy preferences without interference from executive branch staff.

⁵ The listening session held in Burlington was taped by CCTV. It can be seen here: <http://www.cctv.org/watch-tv/programs/health-care-reform-financing-listening-sessions>

After settling on a format, staff designed three activities that would provide sufficient background information to discuss aspects of health care reform financing in small groups and express policy preferences:

1. Executive branch staff would use a presentation to provide a baseline level of knowledge to participants regarding the current health care system and health care reform.
2. Executive branch staff would provide a short presentation on the use of principles to guide policy making and empower small groups of participants to engage in an exercise to discuss and express preferences for policy principles that could guide health care reform financing.
3. Executive branch staff would provide a short presentation on health care financing and the State's financing and empower small groups to discuss the impact of various potential funding sources for health care reform financing and express preferences for various potential funding sources.⁶

Executive branch staff would circulate during the small group exercises to listen and learn from the conversations of participants and answer questions if necessary.⁷

2.3 Execution of Health Care Reform Financing Listening Sessions

The Administration set forth the presentation and exercises described above in four listening sessions across Vermont in the winter of 2011-2012. These sessions were held on the following dates in the following places:

- November 29, 2011. Brattleboro, Vermont. Marlboro College.
- December 13, 2011. Rutland, Vermont. Rutland Free Library.
- December 14, 2011. Burlington, Vermont. Burlington Sheraton.

⁶ Appendix B contains the PowerPoint slides used during the health care reform financing listening sessions. Appendix C contains the handouts that guided participants through the small group exercises.

⁷ Staff from the Agency of Administration, Agency of Human Services, and Agency of Commerce and Community Development participated in these listening sessions. This included the Secretary of Administration, Secretary of Commerce and Community Development, Commissioner of Taxes, Commissioner of the Department of Public Health, Commissioner of the Department of Vermont Health Access, members of the Green Mountain Care Board, Director of Health Care Reform, and staff from BISHCA and the Department of Taxes.

- February 23, 2012. St. Johnsbury, Vermont. Catamount Arts Center.

The results of the exercises collected at these forums are set forth in the next sections of the report.

2.4 Placing Health Care Reform Financing in Context⁸

Participants arrived at the listening sessions with varying levels of knowledge regarding our health care system and health care reform. The first task was to provide sufficient background information to begin a discussion of health care reform financing. Staff developed and provided information regarding the timeline and process for health care reform generally and the financing plans specifically. Also, staff presented information on pressures that make health care reform an imperative for Vermont. These included slides on how Vermonters are spending more for health care and getting less, how health care costs are squeezing Vermonters and their doctors, and the opportunity presented by health care reform. Slides three through eight in Appendix B provide this relevant background information.

2.5 Exercise 1: Principles of Health Care Reform Financing

The first public engagement exercise was designed to provide participants with the opportunity to express policy principles that could guide the policy choices that must be made in designing a health care reform financing plan. The format was a brief background presentation followed by a 30 minute small group exercise.⁹

Background Information for the Exercise

The presentation focused on principles of a health care finance system, explaining the use of principles in designing financing systems and why they are important. Typically, principles are central to the development of public policy, as they provide a point of reference to design and

⁸ See Appendix B slides 3- 8.

⁹ See Appendix B slides 9 through 17 for the presentation materials.

evaluate a system and promote transparency. Participants were informed that they should consider principles as specific, actionable advice to policymakers that ensures policy reflects a community's vision of desired outcomes. Also, participants were advised that principles are a best practice in state revenue and financing studies.

Next, participants were provided with examples of principles in the context of financing plans. For example, many tax systems honor the principle of equity. That is a revenue system should take into account ability to pay. This principle is apparent in the design of the progressive federal and state income tax systems. Another example provided was stability. Some states, like Vermont, rely on a broad mix of revenue sources and typically experience less volatility than states who are reliant on a narrow range of revenue streams.¹⁰ The tension between principles was illustrated by discussing the example principle of exportability. For example, Alaska receives 83% revenue from oil royalties, allowing it to export its tax base.¹¹ A state like Vermont, which wants to attract tourists, may be hesitant to enact tax policies that target out of state payers.

Given this background information, participants were asked to review the small group exercise sheet provided for the policy principle discussion. The sheet contained fourteen policy principles that could shape the design of the health care reform financing proposals. These principles were developed in accordance with the general financing principle set forth in Act 48, that the financing system be sufficient, fair, predictable, transparent, sustainable, and shared equitably.¹² The principles are set forth below with a brief explanation offered by staff to participants to reinforce the meaning of each principle.

¹⁰ See Cornia and Nelson, Federal Reserve Bank of St. Louis *Regional Economic Development*, 2010, 6(1), pp.23-58. Available online at <http://research.stlouisfed.org>. The paper highlights the balance and volatility of state tax systems.

¹¹ Ibid.

¹² See Act 48 of 2011 §1a (11).

Principles to Consider when Designing a Health Care Reform Financing Proposal¹³

Categorical Principle: Equity

A financing system that is...

1. Universal in paying for the health care coverage of all Vermonters
 - The financing system must be sufficient to pay for everyone
2. Universal in participation of all Vermonters
 - The financing system must include contributions from everyone
3. Progressive by taking into account ability to pay for coverage
 - A financing system should be based in part on ability to pay, acknowledging that ability to pay is a difficult concept to agree upon and implement. .
4. Uniform in placing similar burdens on individuals in similar circumstances
 - A financing system should ensure that people are treated the same if similarly situated.

Categorical Principle: Sustainability

A financing system that is...

5. Balanced with diverse revenue sources for reliable, sufficient funding that capitalizes on federal funds available for health care
 - A financing system should strive for a balanced revenue mix that leaves Vermont less vulnerable to downturns or changes in one revenue type.
6. Simple for ease and efficiency in compliance and administration
 - People should understand their obligations under the financing plan and how to comply with them.
7. Transparent and accountable to Vermonters as payers, patients and providers
 - The financing plan should emphasize the ability of people to understand how it works and hold its administrators accountable for their choices.
8. Predictable with certainty for payers, patients and providers
 - The financing plan should avoid wild fluctuations and changes so that people and business can make plans based on reasonable expectations of the future.
9. Sensitive to interstate and international economic pressures for Vermont businesses
 - Vermont competes with other states and countries across the globe. The financing plan ought to reflect that fact.

¹³ The principles were grouped into three categories. These over-arching categorical principles were equity, stability, and affordability.

10. Non-disruptive with transitional provisions for Vermont individuals and businesses
 - While the financing plan will change existing relationships, this principle would have the financing plan emphasize specific transition strategies to minimize the impact of those transition issues.

Categorical Principle: Affordability

A financing system that is...

11. Innovative with incentives for good health and disease management
 - The financing should cost less for people that maintain good health and cost more for those that engage in unhealthy choices.
12. Encouraging of awareness of health care costs and appropriate elasticity of demand for health care services
 - The financing plan should be structured to encourage easy, affordable access to necessary preventative care and other drivers of overall good health.
13. Supportive of the goal of paying providers the same regardless of payer so that there is no cost shift from public programs to the private insurance market
 - The financing system should eliminate incentives to shift the type of care based on cost.
14. Encouraging of providers relocating to Vermont
 - The financing system should be designed to provide an incentive for providers to locate and remain in Vermont.

During the small group exercise, participants gathered in groups usually between six and eight people. They were instructed to choose a facilitator and perform the following tasks.

The Exercise

First, each participant was asked to complete the following question the first time around the group: *Principle X (chosen preferred principle) is important for health care finance reform because (provide rationale for emphasizing that principle.)* Second, each participant was asked to complete the following question the second time around the group: *Principle X (chosen least desired principle) is not so important for health care finance reform to me because (provide rationale for deemphasizing that principle.)* Groups then discussed these choices together for approximately 30 minutes.

After the group discussion, participants were asked to choose up to three preferred principles and write them on a green card. Each participant was asked to choose one least desired principle and write this principle on a yellow card. These cards were collected at each forum to provide public input about the principles that should guide the design of a health care finance system, principles that perhaps should be emphasized less, and principles that illustrate the difficulty of designing a system that is mutually agreeable to Vermonters.

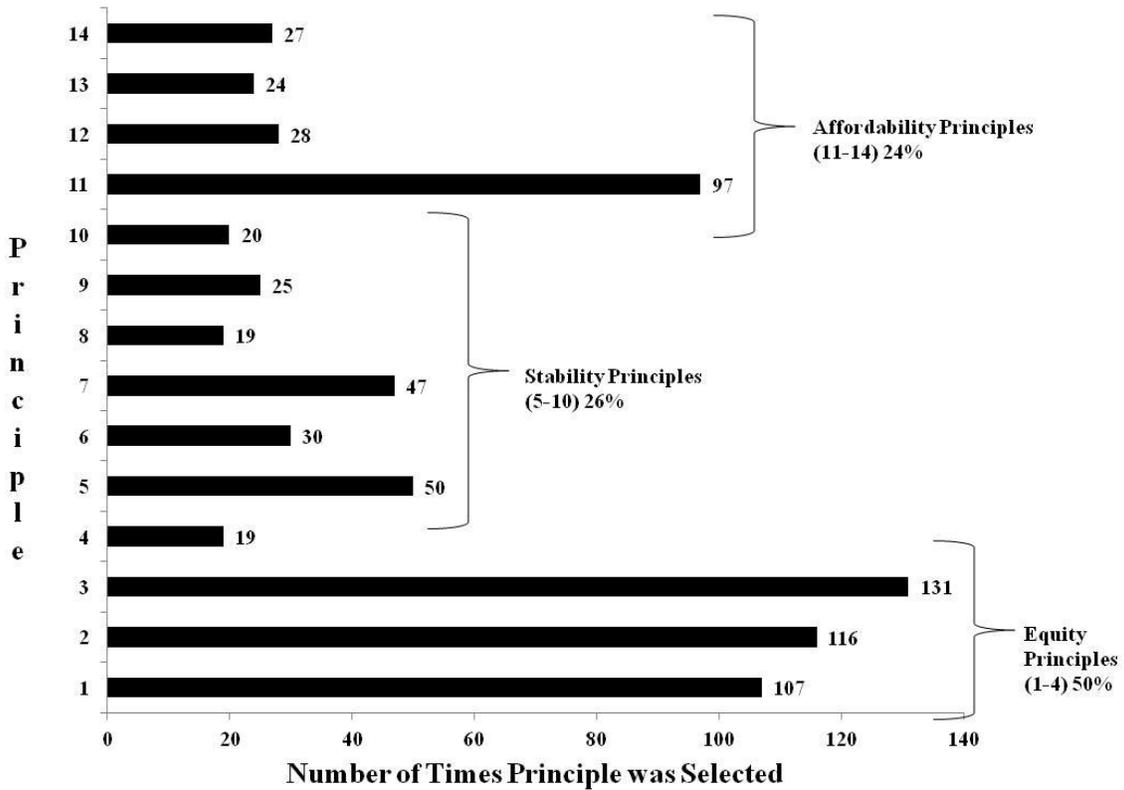
Before a discussion of the data, it is important to acknowledge that the listening session exercises were not intended as a scientific survey. The exercises were designed to capture generally the sentiments of those Vermonters who chose to attend the sessions to learn more about health care reform and share their thoughts and preferences. The listening sessions were attended by a self-selecting group. Therefore, the data is not reflective of Vermonters who did not attend or could not attend the sessions. Given these facts, the data within the report is not considered a complete analysis of the policy preferences of Vermonters. Overall, the data should be considered a useful guidepost to policymakers and one of many valuable aids in the formulation of the financing plans between now and January 15, 2013.

Data and Analysis

Figure 1¹⁴ on the next page depicts participant preferences for principles to guide the formulation of the financing plan aggregated for all sites. The principle numbers 1-14 correspond to the list of policy preferences presented previously in the section. Figure 1 focuses on the categorical principles, as demonstrated by the brackets to the right of the principles.

¹⁴ The figures and tables in this section of the report use the number of times a preference was expressed as its data. It is important to remember that participants were asked to list up to three principles that they supported. Some participants expressed more or fewer or none at all. Staff did not count more than three principles on any participant submission. Overall, and by design, there is not a 1:1 ratio of preferences expressed to people.

Figure 1: Policy Preferences - Sum of All Listening Sessions



The brackets on the right of the chart divide the fourteen principles into three categorical principles, - equity, stability, and affordability. The broadest measure of the data collected is whether participants expressed a preference for these three over-arching principles. The data above shows that equity was a primary interest of the individuals attending the outreach sessions, as about half of the policy preferences expressed during the exercise were for equity principles, about a quarter were for issues of stability, and about a quarter were for issues of affordability. Other Vermonters that did not attend may not share the same preferences. For the report, it is significant that those that showed up have equity as the key principle and equity may be considered a major driver in moving forward with the development of a financing plan.

Within the categorical principle of equity, three principles received similar high emphasis and one principle received less emphasis. These results are depicted in Table 1:

Table 1: Preference for Equity Principles	Number of Times Principle was Selected
3: Progressive by taking into account ability to pay for coverage	131
2: Universal in participation of all Vermonters	116
1: Universal in paying for the health care coverage of all Vermonters	107
4: Uniform in placing similar burdens on individuals in similar circumstances	19

These choices may signal a preference for a financing system sufficient to pay for all Vermonters, that includes contributions from all Vermonters, and accounts for differences in participant resources. The principle “uniform in placing similar burdens on individuals in similar circumstances” was noticeably less supported under the banner of equity, reflecting that it was not a major driver for the majority of attendees.

Participants expressed a preference for two principles within the overall principle of stability, depicted in Table 2 on the next page:

Table 2: Preference for Stability Principles	Number of Times Principle was Selected
5: Balanced with diverse revenue sources for reliable, sufficient funding that capitalizes on federal funds available for health care	50
7: Transparent and accountable to Vermonters as payers, patients and providers	47
6: Simple for ease and efficiency in compliance and administration	30
9: Sensitive to interstate and international economic pressures for Vermont businesses	25
10: Non-disruptive with transitional provisions for Vermont individuals and businesses	20
8: Predictable with certainty for payers, patients and providers	19

These principles reflect a preference for a balanced revenue mix that leaves Vermont less vulnerable to downturns or changes in one revenue type and that people should understand their obligations under the financing plan and how to comply with them. The level of preference for these principles was relatively modest compared to the three most popular equity principles, being listed less than half the number of times by participants.

Affordability was the final categorical principle. Participants expressed a strong preference for one affordability principle and a much more modest preference for the three others, as depicted by Table 3 on the next page:

Table 3: Preference for Affordability Principles	Number of Times Principle was Selected
11: Innovative with incentives for good health and disease management	97
12: Encouraging of awareness of health care costs and appropriate elasticity of demand for health care services	28
14: Encouraging of providers relocating to Vermont	27
13: Supportive of the goal of paying providers the same regardless of payer so that there is no cost shift from public programs to the private insurance market .	24

The principle “incentives for good health and disease management” received more support than the three other affordability principles combined. This preference expressed by participants may mean that the idea of incentivizing the financing system to encourage healthy behaviors resonates with many people.

Overall, participants identified four principles as most preferential. These were the three equity principles and one affordability principle regarding incentives for healthy choices and good health. These most preferred principles are set forth below in Table 4.

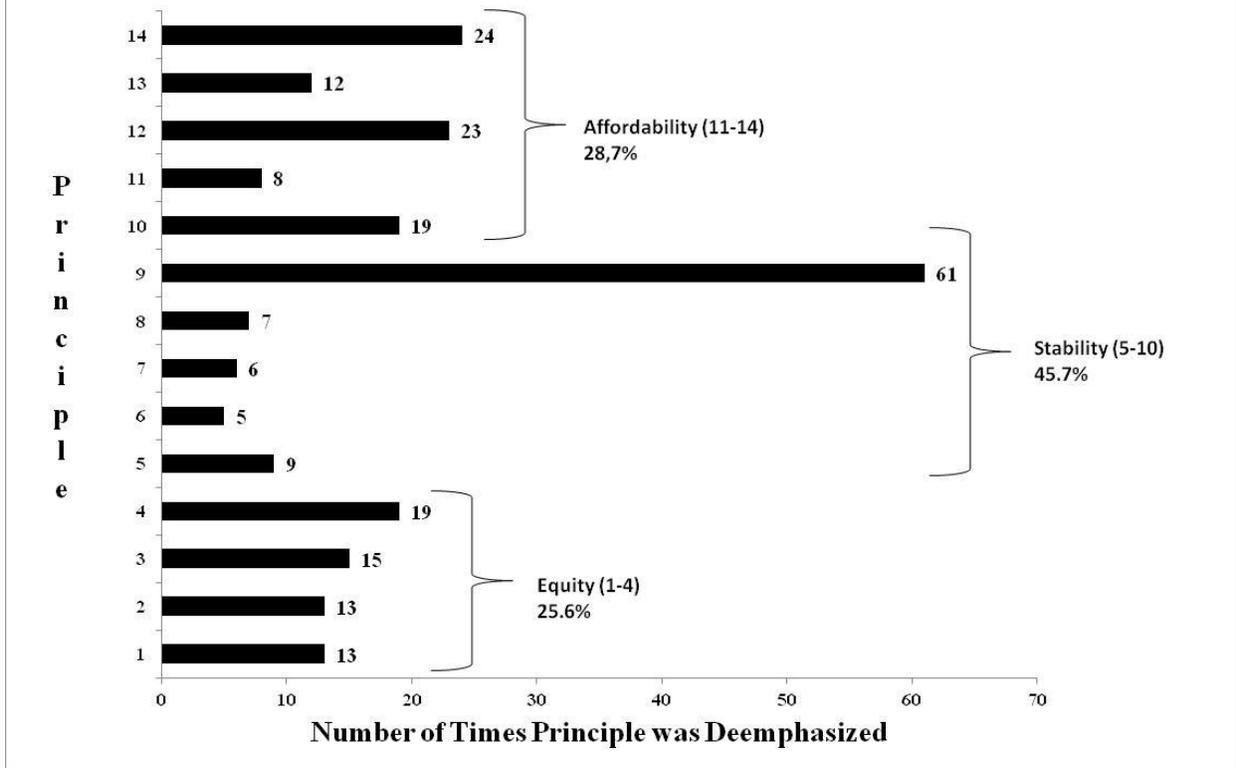
Table 4: Strongest Principle Preferences for Designing Health Care Financing Plan	Number of Times Principle was Selected
3: Progressive by taking into account ability to pay for coverage	131
2: Universal in participation of all Vermonters	116
1: Universal in paying for the health care coverage of all Vermonters	107
11: Innovative with incentives for good health and disease management	97

These preferences would indicate that the participants preferred the administration to focus on equity, designing a system that is sufficient to pay for the health care of all Vermonters, requires that all Vermonters pay into the system, and takes into account ability to pay. Simultaneously, participants preferred that the financing plan provide incentives so that those making healthy choices and living in good health can pay less. There was some correlation between the individuals that put an emphasis on financial incentives for good health and healthy choices with those placing an emphasis on equity, with almost 60 percent of those emphasizing incentives also emphasizing an equity principle. The overall message, echoed by both the principles and during observation of small group conversations, is that Vermonters may have a preference for a finance plan that cares for all Vermonters but expects everyone to contribute and encourages everyone to make healthy, responsible choices.

Also, the small group exercise asked participants to choose a single principle that ought to be deemphasized in the formulation of a health care reform financing plan.¹⁵ The data demonstrates a lack of consensus on what should be deemphasized. Figure 2 depicts participant preferences for principles to be deemphasized in the formulation of the financing plan aggregated for all sites. The principle numbers 1-14 correspond to the list of policy preferences presented previously in the section. Figure 2 focuses on the categorical principles as demonstrated by the brackets to the right of the principles.

¹⁵ Two important features distinguish this data from the preferred principle data beyond the question being asked of participants. First, participants were asked to list only one principle to deemphasize. Second, fewer participants filled out a yellow card. Observations of staff at the listening session observed participants that refused to deemphasize a principle, arguing that all principles were important to the development of a financing plan.

**Figure 2: Policy Preference to be Deemphasized
Sum of All Listening Sessions**



The figure demonstrates that while participants deemphasized stability compared to equity and affordability none of the three categorical principles received a majority of votes.

Examining the fourteen individual principles, participants expressed a wide variety of preferences. Every principle received at least two percent of the votes. Five principles received between two and five percent of the votes. Seven of the principles received between five and ten percent of the votes. Only two principles received greater than ten percent. Full results by percentage are set forth below in Table 5.

Table 5: Principles to Consider Deemphasizing in the Formulation of Financing Plans	Percentage of Votes to Deemphasize
9: Sensitive to interstate and international economic pressures for Vermont businesses	26.1%
14: Encouraging of providers relocating to Vermont	10.3%
12: Encouraging of awareness of health care costs and appropriate elasticity of demand for health care services	9.8%
4: Uniform in placing similar burdens on individuals in similar circumstances	8.1%
10: Non-disruptive with transitional provisions for Vermont individuals and businesses	8.1%
3: Progressive by taking into account ability to pay for coverage	6.4%
1: Universal in paying for the health care coverage of all Vermonters	5.6%
2: Universal in participation of all Vermonters	5.6%
13: Supportive of the goal of paying providers the same regardless of payer so that there is no cost shift from public programs to the private insurance market	5.1%
5: Balanced with diverse revenue sources for reliable, sufficient funding that capitalizes on federal funds available for health care	3.8%
11: Innovative with incentives for good health and disease management	3.4%
8: Predictable with certainty for payers, patients and providers	3.0%
7: Transparent and accountable to Vermonters as payers, patients and providers	2.6%
6: Simple for ease and efficiency in compliance and administration	2.1%

One principle received note as a principle that deserved decreased emphasis, - sensitive to interstate and international economic pressures for Vermont businesses. This principle received more votes than any other; however, only 26% of participants selected the principle. This means that 74% of participants, a strong majority, chose another principle to deemphasize.

Policymakers may decide that additional outreach is needed to determine the strength of this preference, including specific outreach to targeted stakeholder groups. Also, policymakers may view this data and decide that explaining the importance of maintaining and enhancing Vermont's economic competitiveness through health care reform is essential to the development of the finance plans.

Geographical Variations

There was some variation in the selection of policy preferences by participants by geography. Table 6 on the next page sets forth the number of times that each preference was expressed by geography and the ranking of principles at each listening session.

Table 6: Principles to Emphasize in the Financing Plan by Listening Session - Number of Votes and (Rank at Location)	Burlington	Rutland	Brattleboro	St. Johnsbury
1: Universal in paying for the health care coverage of all Vermonters	48 (1)	24 (3)	20 (3)	15 (3)
2: Universal in participation of all Vermonters	44 (4)	34 (1)	20 (3)	18 (2)
3: Progressive by taking into account ability to pay for coverage	48 (1)	30 (2)	34 (1)	19 (1)
4: Uniform in placing similar burdens on individuals in similar circumstances	11 (11)	4 (14)	2 (13)	2 (8)
5: Balanced with diverse revenue sources for reliable, sufficient funding that capitalizes on federal funds available for health care	24 (5)	10 (5)	12 (5)	4 (6)
6: Simple for ease and efficiency in compliance and administration	13(8)	9 (7)	4 (10)	4 (6)
7: Transparent and accountable to Vermonters as payers, patients and providers	22 (6)	10 (5)	9 (6)	6 (4)
8: Predictable with certainty for payers, patients and providers	9 (13)	5 (12)	5 (9)	0 (10)
9: Sensitive to interstate and international economic pressures for Vermont businesses	13 (8)	8 (10)	4 (10)	0 (10)
10: Non-disruptive with transitional provisions for Vermont individuals and businesses	10 (12)	5 (12)	0 (14)	5 (5)
11: Innovative with incentives for good health and disease management	48 (1)	24 (3)	23 (2)	2 (8)
12: Encouraging of awareness of health care costs and appropriate elasticity of demand for health care services	12 (10)	9 (7)	7 (8)	0 (10)
13: Supportive of the goal of paying providers the same regardless of payer so that there is no cost shift from public programs to the private insurance market	8 (14)	8 (10)	8 (7)	0 (10)
14: Encouraging of providers relocating to Vermont	15 (7)	9 (7)	3 (12)	0 (10)
TOTAL	325	189	151	75

Overall, geographic variation was low in expressing policy preferences. Perhaps notable is that the Rutland session did not have progressivity as its top principle, unlike the other sessions (Participants in Rutland ranked progressivity second). Instead, Rutland participants ranked the principle calling for everyone to contribute financially as their top preference, though the difference was only four votes. Also, St. Johnsbury participants ranked “innovative with incentives for good health and disease management” eighth, whereas the other sessions ranked it in the top three. The significance of this variation is hard to assess, as the St. Johnsbury listening session was less than half the size of the other sessions.

There was some geographic variation in preferences for a principle to deemphasize. For example, participants at all listening sessions but Rutland chose to deemphasize sensitivity to economic pressures for business. Participants in Rutland chose to deemphasize “universal in paying for the health care coverage of all Vermonters” more than any other principle. This was the second most popular principle to deemphasize at the Burlington session as well. This may be seen as a rejection by certain participants of the premise of health care reform. It is important to note that at the Rutland listening session participants supported that same principle by a margin of 2:1 and in Burlington participants supported that same principle by a margin of 4:1. The entire set of results regarding the deemphasizing of a principle by listening session is set forth in Table 7 on the next page.

Table 7: Principles to Deemphasize in the Financing Plan by Listening Session - Number of Votes and (Rank at Location)	Burlington	Rutland	Brattleboro	St. Johnsbury
1: Universal in paying for the health care coverage of all Vermonters	2 (12)	11 (1)	0 (12)	0 (7)
2: Universal in participation of all Vermonters	8 (6)	4 (6)	1 (10)	0 (7)
3: Progressive by taking into account ability to pay for coverage	11 (2)	4 (6)	0 (12)	0 (7)
4: Uniform in placing similar burdens on individuals in similar circumstances	6 (8)	4 (6)	3 (5)	6 (1)
5: Balanced with diverse revenue sources for reliable, sufficient funding that capitalizes on federal funds available for health care	3 (11)	4 (6)	2 (7)	0 (7)
6: Simple for ease and efficiency in compliance and administration	4 (9)	0 (14)	1 (10)	0 (7)
7: Transparent and accountable to Vermonters as payers, patients and providers	4 (9)	1 (13)	0 (12)	1 (4)
8: Predictable with certainty for payers, patients and providers	2 (12)	2 (10)	3 (5)	0 (7)
9: Sensitive to interstate and international economic pressures for Vermont businesses	30 (1)	6 (2)	19 (1)	6 (1)
10: Non-disruptive with transitional provisions for Vermont individuals and businesses	9 (4)	2 (10)	7 (3)	1 (4)
11: Innovative with incentives for good health and disease management	1 (14)	5 (5)	2 (7)	0 (7)
12: Encouraging of awareness of health care costs and appropriate elasticity of demand for health care services	11 (2)	6 (2)	4 (4)	2 (3)
13: Supportive of the goal of paying providers the same regardless of payer so that there is no cost shift from public programs to the private insurance market	7 (7)	2 (10)	2 (7)	1 (4)
14: Encouraging of providers relocating to Vermont	9 (4)	6 (2)	8 (2)	1 (4)
TOTAL	107	57	52	18

2.6: Exercise 2, Health Care Reform Funding Sources

The second public engagement exercise was designed to provide participants with the opportunity to express preferences for various potential funding sources that could be used within a health care reform financing proposal. The format was a brief background presentation followed by a 30 minute small group exercise.¹⁶

Background Information for the Exercise

The background presentation provided information on government funding generally, payers and funding sources in the current health care system, and compared current health care expenditures to state revenues. Also, the presentation provided participants with considerations. These considerations were designed to help participants wrestle with some of the difficult issues and tensions that exist in financing health care. The key elements of the background presentation are summarized below.

The background presentation made a necessary distinction between how we fund the government generally and how we fund health care under current law. Government is paid for typically by general taxes or taxes collected for a specific purpose, i.e. gasoline taxes that pay for transportation projects. Health care is fundamentally different, functioning like a funnel with myriad funding sources.

Next, the presentation focused on who pays for health care under the current system and how they pay for it. Individuals pay for health care in several ways, including beneficiary premiums, out of pocket spending, and taxes. Health care providers pay both taxes and assessments. Employers pay for health care through insurance premiums, assessments, and general taxes. Government entities pay for health care while playing several roles, including

¹⁶ See Appendix B slides 14 through 27 for the presentation materials. See Appendix C for the handout used by participants.

health care provider, employer, and payer. Participants were provided with the total amount of these expenditures and the proportion in which each party paid.¹⁷

Participants were asked to consider the direct and indirect ways in which they, as individuals, pay for health care. Individuals pay for health care costs both directly and indirectly. Directly, individuals pay for health care through insurance premiums, out of pocket expenditures, and consumption taxes. Indirectly, individuals pay for health care through federal, state, and local taxes; taxes passed on to consumers by health care providers, and foregone wages as employers offer health care benefits in lieu of direct wages.

Staff presented information on federal financing of health care. Participants were informed that Vermont cannot direct federal payments without a waiver from the federal government, of which Vermont currently has several. Staff noted that federal funds are estimated to increase by \$300-\$400 million beginning in 2014 due to the Affordable Care Act. For the purpose of the exercise, participants were instructed not to consider federal funding sources.

Next, the presentation focused on how Vermont finances state government. Each major funding source or tax type was presented with its projected value for Fiscal year 2012 and the proportion of each to the whole.¹⁸ The presentation compared the size of health care expenditures to the size of general state expenditures. For example, in 2012, Vermonters are expected to pay more directly for health care through insurance premiums and out of pocket benefits than the total amount of the entire General Fund or Education Fund maintained by the State. Participants were asked to wrestle with the scope of these expenditures.

¹⁷ See Appendix B slides 18 - 19.

¹⁸ See Appendix B slides 22 - 23.

Next, participants were introduced to potential revenue sources that may fund portions of the health care reform financing plans. Participants were told that the administration, legislature, and Vermonters must make choices in health care finance, and the exercise would ask participants to consider the mix of funding sources described during the presentation. These included the following mix of funding sources that may be considered to fund a unified and universal health care system in Vermont.

- Individuals: Beneficiary Premiums
- Individuals: Out of Pocket Spending
- General tax on Businesses
- Payroll Tax on both Businesses and Individuals
- Income Tax
- Property Tax
- Consumption Taxes
- Other

Participants were asked to address eight considerations when evaluating potential revenue sources.

1. The incidence of revenue streams (who pays)
2. Wage earner contributions v. non-wage earner contributions
3. The way in which revenue streams influence behavior
4. The ability of the financing sources to sustain your health care priorities over time. For example, taxes collected on cigarettes tend to decrease over time as people stop smoking.
5. The impacts and fairness of financing on individuals
6. The impacts on the business and provider communities
7. The relationship between principles and funding sources
8. The way in which people utilize health care over time. Specifically, participants were shown a chart depicting how in any given year a very small group of people drive most health care expenditures.

The discussion of these considerations provided participants with context to help refine and express their preferences.

The Exercise

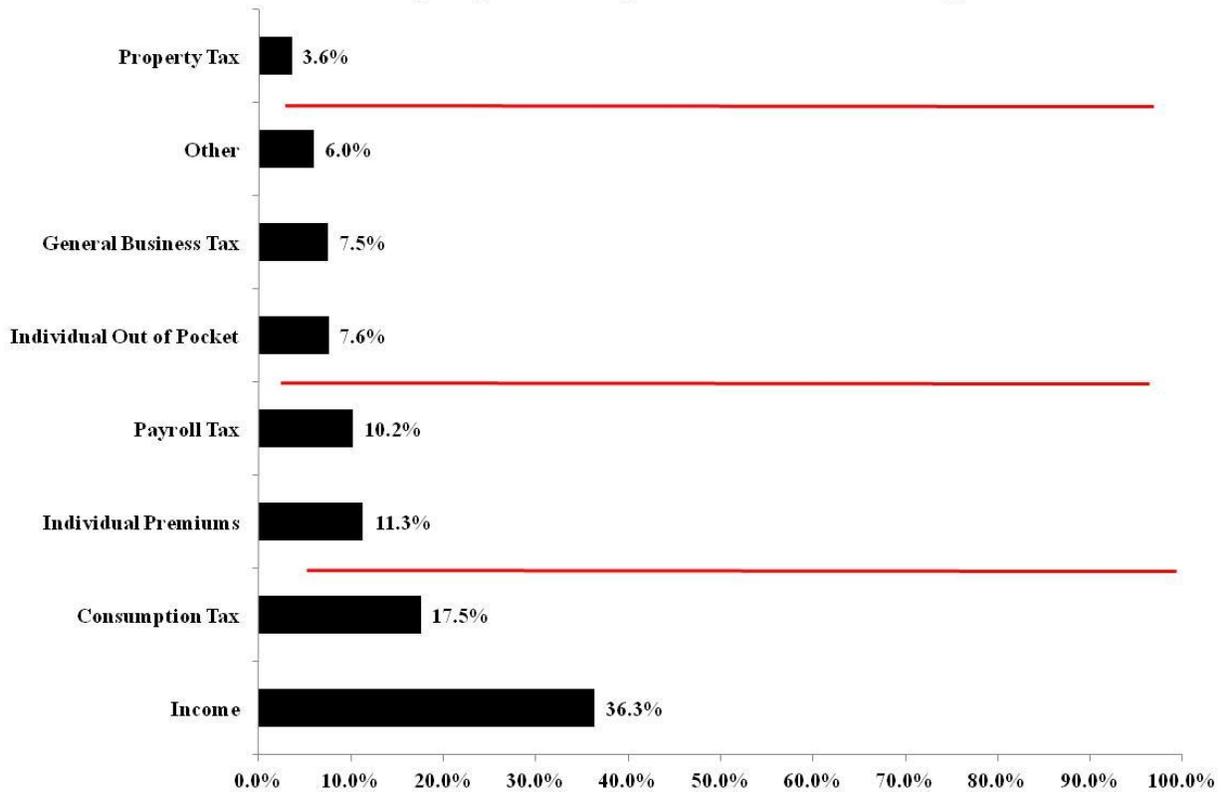
Participants gathered in small groups, typically between 6 and 8 people and were instructed to choose a facilitator. Each participant was asked to complete the following question the first time around the circle: I believe that (funding source/mix of funding sources) reflects the principles I selected earlier. Next, participants were asked to complete a second question during the second time around the circle: as an individual, provider, or business owner, I am most concerned with (funding source/mix of funding sources) because it (state reasons)? All meeting attendees are provided an envelope with \$1,000 of money (in \$100 denominations – 10 X \$100). Boxes were displayed representing the non-federal and provider funding sources described during the presentation and listed above.¹⁹ After discussion around the circle, participants were asked to put what they believe to be the proper allocation of their money into the boxes to fund Vermont's future health care program.

Data and Analysis

The overall results revealed that participants expressed a preference for a broad range of funding sources. Figure 3 depicts the percentage of dollars allocated by participants from all listening sessions for each funding source, with lines grouping funding sources together that received a similar level of preference.

¹⁹ Federal funding and provider taxes were excluded from participant preferences since Vermont cannot direct federal funding without a waiver from the government and provider taxes were considered too complex for discussion. Also, provider taxes are generally passed on to individuals and therefore represent another individual expense, which would be reflected in other funding source preferences.

Figure 3: Funding Source Preferences
Divided into Groups by Percentage - Sum of All Listening Session



The diversity of funding source preferences is striking. Each source received some dollars, none received a majority of dollars, and only one source received more than one-third. It is a reasonable inference that Vermonters may prefer a financing plan with a diverse and balanced mix of revenues, given this data and the moderate preference for the principle that health care financing should be “balanced with diverse revenue sources for reliable, sufficient funding that capitalizes on federal funds available for health care.”²⁰

Another finding is that the preference to tax property while financing health care is very weak despite this broad range of preferences. Accordingly, participants seem to indicate that the State should develop a health care reform financing plan that likely does not consider the use of property taxes.

²⁰ This was preference 5 in the report’s previous section.

Perhaps the strongest inference to be drawn from Figure 3 is that participants may have connected their selection of principles to emphasize with their preferences for funding sources beyond valuing a balanced revenue mix. Individuals emphasized principles that supported equity and healthy choices/good health. The two most popular funding source selections mirror these choices. A progressive income tax tends to be an equitable tax that focuses on an individual's ability to pay. A consumption tax tends to emphasize choices, though they tend to be regressive. Accordingly, the most preferred principles and funding sources seem to be in some alignment.

Geographic Variations

All listening sessions listed income tax as a preferred funding source; however, it is important to recall that participants expressed mixed preferences regarding funding sources. No group of listening session participants expressed a majority preference for a single funding source. Table 8 on the next page depicts the allocation of preferences for funding sources by listening session with both the number of votes and rank.

Table 8: Funding Source Preferences by Listening Session	Burlington	Rutland	Brattleboro	St. Johnsbury	Total
Income Tax	519 (1)	245 (1)	205 (1)	127 (1)	1096 (1)
Consumption Tax	214 (2)	143 (2)	141 (2)	31 (4)	529 (2)
Individual Premiums	141 (3)	96 (4)	81 (3)	23 (5)	341 (3)
Payroll Tax	133 (4)	106 (3)	32 (7)	36 (3)	307 (4)
Individual Out of Pocket	68 (7)	93 (5)	59 (4)	9 (8)	229 (5)
General Business Tax	93 (5)	32 (7)	53 (5)	48 (2)	226 (6)
Other	83 (6)	56 (6)	31 (8)	11 (7)	182 (7)
Property Tax	27 (8)	30 (8)	38 (6)	13 (6)	108 (8)
Total by Session²¹	1279	801	640	298	3018

Overall, geographic variation was modest. All funding sources received votes at all sessions. Also, the selection of “Other” as a funding source was low at all sessions. In most cases, participants ranked funding source preferences within one or two ranks of their sister site. There were several notable exceptions.

Brattleboro participants expressed a far lower preference for the payroll tax than other listening sessions, being three and four ranks below sister sites. St. Johnsbury participants ranked a general tax on business second, whereas that funding source was ranked fifth in Burlington and

²¹ Totals in Table 8 reflect the number of individual bills cast for each funding source. Recall that each participant was given ten separate bills to allocate between the funding sources depending on their preferences.

Brattleboro and seventh in Rutland. Rutland and Brattleboro ranked individual out of pocket fourth and fifth as a funding source, which helped it rank fifth overall despite the fact that participants in the large Burlington listening session ranked it seventh.

APPENDIX A
2011 LEGISLATIVE DIRECTIVE FROM ACT 48 2011

Sec. 9. FINANCING PLANS

(a) The secretary of administration or designee shall recommend two plans for sustainable financing to the house committees on health care and on ways and means and the senate committees on health and welfare and on finance no later than January 15, 2013.

(1) One plan shall recommend the amounts and necessary mechanisms to finance any initiatives which must be implemented by January 1, 2014 in order to provide coverage to all Vermonters in the absence of a waiver from certain federal health care reform provisions established in Section 1332 of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as further amended (“Affordable Care Act”).

(2) The second plan shall recommend the amounts and necessary mechanisms to finance Green Mountain Care and any systems improvements needed to achieve a public-private universal health care system. The secretary shall recommend whether nonresidents employed by Vermont businesses should be eligible for Green Mountain Care and solutions to other cross-border issues.

(b) In developing both financing plans, the secretary shall consider the following:

(1) all financing sources, including adjustments to the income tax, a payroll tax, consumption taxes, provider assessments required under 33 V.S.A. chapter 19, the employer assessment required by 21 V.S.A. chapter 25, other new or existing taxes, and additional options as determined by the secretary;

(2) the impacts of the various financing sources, including levels of deductibility of any tax or assessment system contemplated and consistency with the principles of equity expressed in 18 V.S.A. § 9371;

(3) issues involving federal law and taxation;

(4) impacts of tax system changes:

(A) on individuals, households, businesses, public sector entities, and the nonprofit community, including the circumstances under which a particular tax change may result in the potential for double payments, such as premiums and tax obligations;

(B) over time, on changing revenue needs; and

(C) for a transitional period, while the tax system and health care cost structure are changing;

(5) growth in health care spending relative to needs and capacity to pay;

(6) anticipated federal funds that may be used for health services and how to maximize the amount of federal funding available for this purpose;

(7) the amounts required to maintain existing state insurance benefit requirements and other appropriate considerations in order to determine the state contribution toward federal premium tax credits available in the Vermont health benefit exchange pursuant to the Affordable Care Act;

(8) additional funds needed to support recruitment and retention programs for high-quality health care professionals in order to address the shortage of primary care professionals and other specialty care professionals in this state;

(9) additional funds needed to provide coverage for the uninsured who are eligible for Medicaid, Dr. Dynasaur, and the Vermont health benefit exchange in 2014;

(10) funding mechanisms to ensure that operations of both the Vermont health benefit exchange and Green Mountain Care are self-sustaining;

(11) how to maximize the flow of federal funds to the state for individuals eligible for Medicare, such as enrolling eligible individuals in Medicare and paying or supplementing the cost-sharing requirements on their behalf;

(12) the use of financial or other incentives to encourage healthy lifestyles and patient self-management for individuals enrolled in Green Mountain Care;

(13) preserving retirement health benefits while enabling retirees to participate in Green Mountain Care;

(14) the implications of Green Mountain Care on funds set aside to pay for future retiree health benefits; and

(15) changes in federal health funding through reduced payments to health care professionals or through limitations or restrictions on the availability of grant funding or federal matching funds available to states through the Medicaid program.

(c) In developing the financing plan for Green Mountain Care, the secretary of administration or designee shall consult with interested stakeholders, including health care professionals, employers, and members of the public, to determine the potential impact of various financing sources on Vermont businesses and on the state's economy and economic climate. No later than February 1, 2012, the secretary or designee shall report his or her findings on the impact on businesses and the economy and any related recommendations to the house committees on health care and on commerce and to the senate committees on health and welfare, on finance and on economic development, housing and general affairs.

(d) In addition to the consultation required by subsection (c) of this section, in developing the financing plan for Green Mountain Care, the secretary of administration or designee shall solicit input from interested stakeholders, including health care professionals, employers, and members of the public and shall provide opportunities for public engagement in the design of the financing plan.

(e) The secretary of administration or designee shall consider strategies to address individuals who receive health coverage through the Veterans Administration, TRICARE, the Federal Employees Health Benefits Program, the government of a foreign nation, or from another federal governmental or foreign source.

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APPENDIX B
PRESENTATION SLIDES PRESENTED BY STAFF AT THE HEALTH CARE REFORM
FINANCING LISTENING SESSIONS

HEALTH CARE REFORM
FINANCING:
LISTENING SESSION

December 14, 2011

WELCOME

2

- Thank you for your participation
- Health care reform passed. Where are we now?
- Health care reform as an opportunity
- How we can work together to shape public policy

Why Health Care Reform?

3

- Vermonters are spending more and getting less
 - Spending more:
 - Health care spending more than tripled in Vermont between 1992 and 2009
 - We spent \$2.5 billion on health care ten years ago. We spend about \$5 billion per year now
 - We will spend an additional \$1.6 billion *per year* in just four years without reform
 - **That's almost \$12,000 for a family of four!**

□

Why Health Care Reform?

4

- Vermonter's are spending more and getting less
 - Getting less:
 - 47,000 Vermonters are uninsured despite current level of health spending
 - 150,000 Vermonters are considered underinsured, meaning they have insurance, but their out-of-pocket costs threaten to bankrupt them

Why Health Care Reform?

5

- Health care costs are squeezing Vermonters
 - ▣ Between 1996 and 2006 the average annual premium for family coverage nearly doubled
 - ▣ Health care costs are rising, but Vermonters make, on average, about the same as they made a decade ago
 - ▣ To keep up with health care increases, employers have had to consider:
 - Reducing wage increases
 - Reducing the number of employees
 - Reducing the value of the insurance coverage

Why Health Care Reform?

6

- Current system is squeezing doctors
 - ▣ Doctors are paid on volume, not quality, meaning patient evaluation, management, and quality doesn't pay
 - Stress is acute in primary care
 - ▣ Current system means reams of paperwork – the cost of interacting with insurers is an estimated \$83,000 per year per physician in the U.S. – four times as much as in Canada
- ▣ Narrow margins for many hospitals

Health Care Reform as an Opportunity

7

- Health Care Reform: A system that works for all Vermonters and cares for all Vermonters
 - ▣ Implement a Vermont-style single payer system that invests our substantial investment in health care to cover all Vermonters
 - ▣ Create a wellness and business environment that is a competitive advantage for businesses
 - ▣ Pay providers for *value not volume*

Listening Session's Purpose

8

- Legislature Passed Act 48, An Act Relating to a Universal and Unified Health System
 - ▣ Act 48 requires financing plans to be presented in 2013
 - ▣ Public input is important & necessary to inform the financing plans
 - *“The state must ensure public participation in the design, implementation, evaluation, and accountability mechanisms of the health care system.” –ACT 48*
 - ▣ Listening sessions provide an opportunity to express preferences for the type of principles and funding sources that will help shape the financing plans due in 2013

Organization of the Session

9

□ Principles of a Health Care Finance System

- ▣ What are principles and why are they important?
- ▣ Discuss in small groups
- ▣ Express preferences

□ Potential Funding Sources

- ▣ Funding generally
- ▣ Payers and funding sources
- ▣ Health care expenditures and state revenues
- ▣ Small group exercise

Why are Principles Important to a Financing System?

10

- Provide a point of reference to evaluate system and new proposals
- Promote transparency
- A best practice in state revenue and financing studies

Examples of Principles for a Financing System

11

- Example principle: equity
 - ▣ Revenue system should take into account ability to pay
 - Example, progressive federal & state income tax

- Example principle: exportability
 - ▣ Taxes should be paid by non-residents when possible
 - Example, Alaska receives 83% revenue from oil royalties

- Example principle: stability
 - ▣ Relies on a balanced variety of revenue sources
 - Example, Vermont's revenue mix is among most balanced in Nation

Possible Principles for Health Care Financing

12

- Financing principles developed in accordance with general principles set forth by Act 48
- Potential principles are listed on your handout

Small Group Discussion of Principles

13

- Break out for small group discussions (25 minutes)
- Follow the instructions on the handout
- Express your preference for specific principles on the green and yellow cards

Small Group Discussion Question

14

- Focus the discussion with these questions around the circle:
- **1. (Fill in a chosen preferred principle) is important for health care finance reform because it...**
- **2. (Fill in the least desired principle) is not so important for health care finance reform because...**
- Express your preference for specific principles on the green and yellow cards

Funding Sources for Health Care: Overview

15

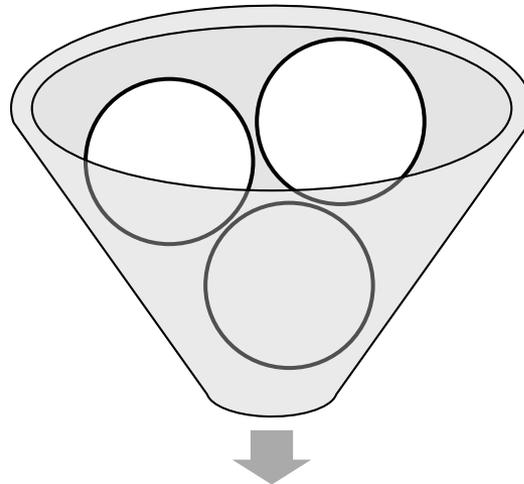
- Funding generally
- Payers and funding sources
- Health care expenditures and state revenues
- Small group exercise

Funding Sources for Health Care Reform: Funding Generally

16



Health Care

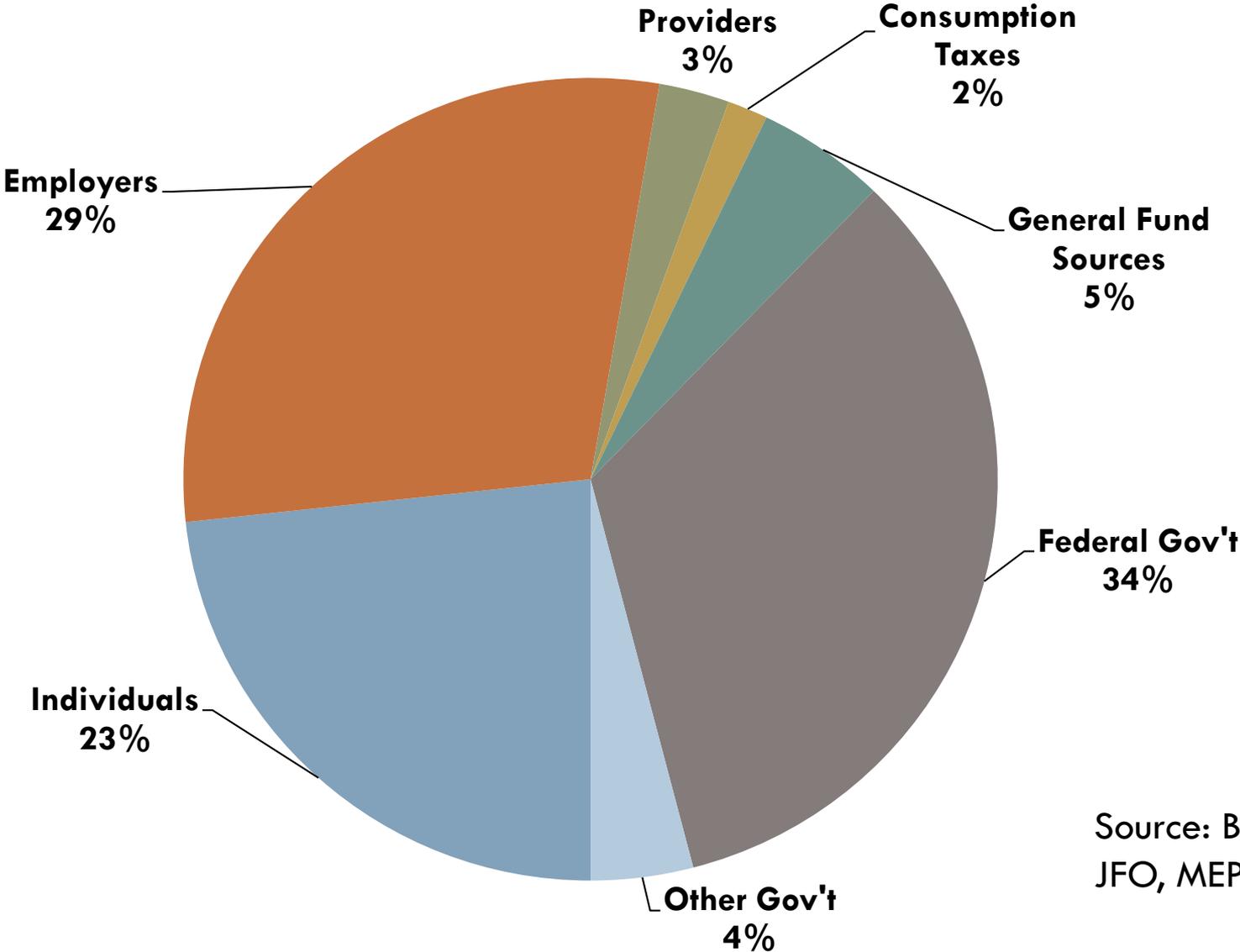


Funding Sources for Health Care Reform: Who Pays and How Do They Pay it?

17

- Individuals: beneficiary premiums, out of pocket spending, and taxes
- Providers: taxes & assessments
- Employers: insurance premiums, assessments, and general taxes
- Government: provider, employer, payer

Funding Sources: Who Pays Now?



Source: BISHCA, JFO, MEPS Data

What Vermonters Pay Now

19

2012 Projected Vermont Health Care Expenditures (Multiply by 1,000)

Individuals	\$1,226,997
Employers	\$1,602,157
Providers	\$130,922
General Fund Sources <i>(Includes Consumption Taxes)</i>	\$240,275
Federal Gov't	\$1,889,478
Other Gov't	\$225,084
Total (NOT NEW REVENUE)	\$5,314,913

Source: BISHCA

Funding Sources for Health Care Reform: Considerations (1)

20

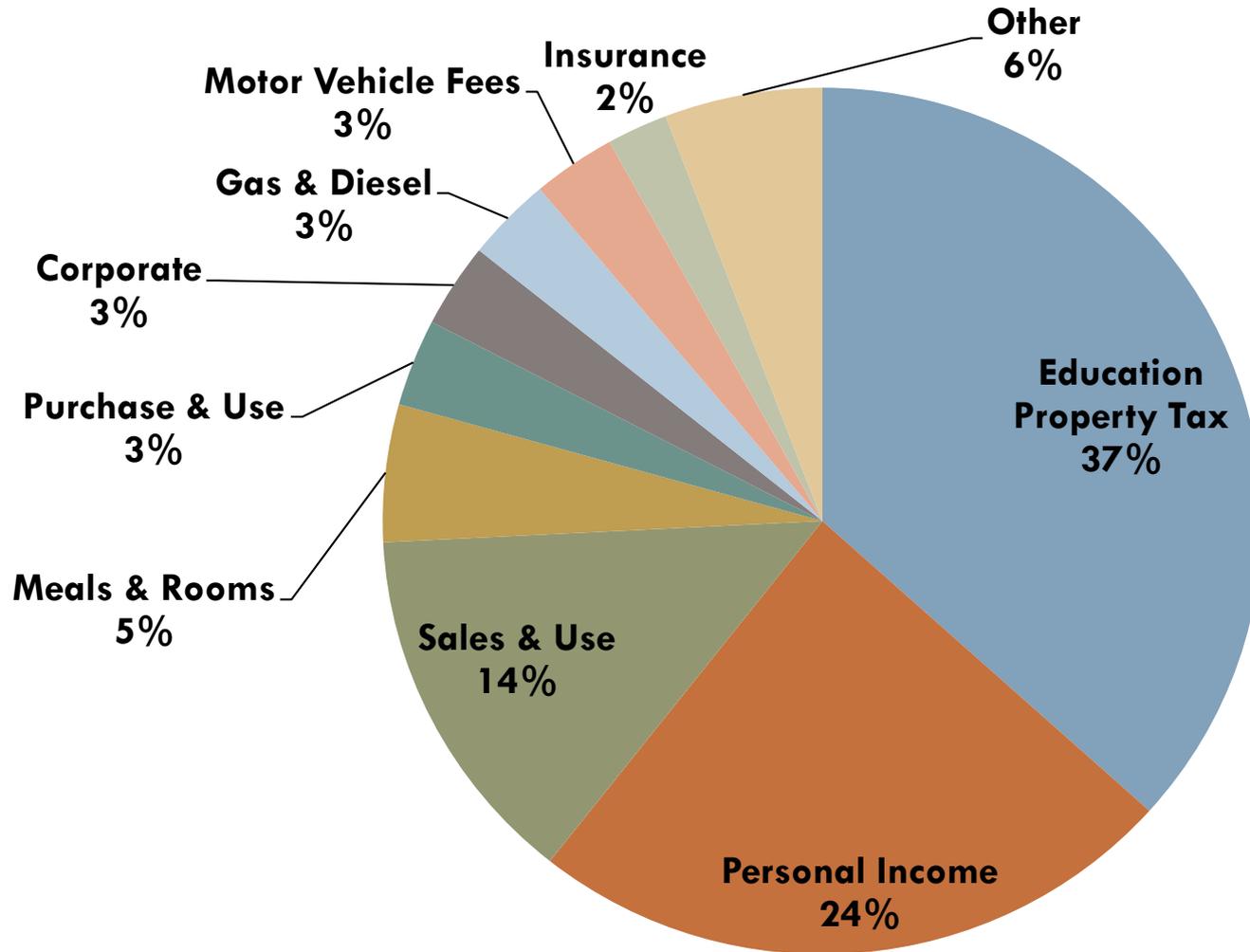
- Direct & Indirect Contributions by Individuals
 - Direct
 - ▣ Premiums
 - ▣ Out of Pocket
 - ▣ Consumption Taxes
 - Indirect
 - ▣ Federal, state, and local taxes
 - ▣ Taxes paid through providers
 - ▣ Foregone wages

Note on Federal Funding of Health Care

21

- Special Note: Federal Sources
 - ▣ Federal government spending
 - Vermont can direct federal payments with permission from the federal government (“waiver”)
 - Medicaid waiver –Vermont currently has 2 waivers
 - Affordable Care Act waiver – 2017
 - Medicare – anticipated to stay the same
 - ▣ Federal funds are estimated to increase by \$300-\$400 million in 2014 through new ACA funds

State Revenues: How We Raise Revenue Now



Source: JFO FY 2012 Projected

Current Law Major Revenue Sources

23

FY 2012 Projected Vermont Revenues (Millions)

Education Property Tax	\$909.3
Personal Income	\$594.8
Sales & Use	\$336.8
Meals & Rooms	\$127.2
Purchase & Use	\$80.6
Corporate	\$78.1
Gas & Diesel	\$78.1
Motor Vehicle Fees	\$76.1
Insurance	\$55.5
Other	\$144
Total	\$2,480.5

Source: JFO

Funding Sources for Health Care Reform: Considerations (2)

24

Projected Health Care Expenditures in 2012

- Individuals directly: \$1.226 billion
- Overall spending: \$5.314 billion

Projected State Revenue by Fund FY 2012

- General Fund: \$1.183 billion
- Education Fund: \$1.071 billion
- Transportation Fund: \$.226 billion

Source: BISHCA & JFO

Potential Funding for Health Care Financing System

25

- Individuals: beneficiary premiums
- Individuals: out of pocket spending for services
- General tax on businesses
- Payroll tax, both businesses and individuals
- Income tax
- Property tax
- Consumption taxes
- Other

Funding Sources for Health Care Reform: Considerations (3)

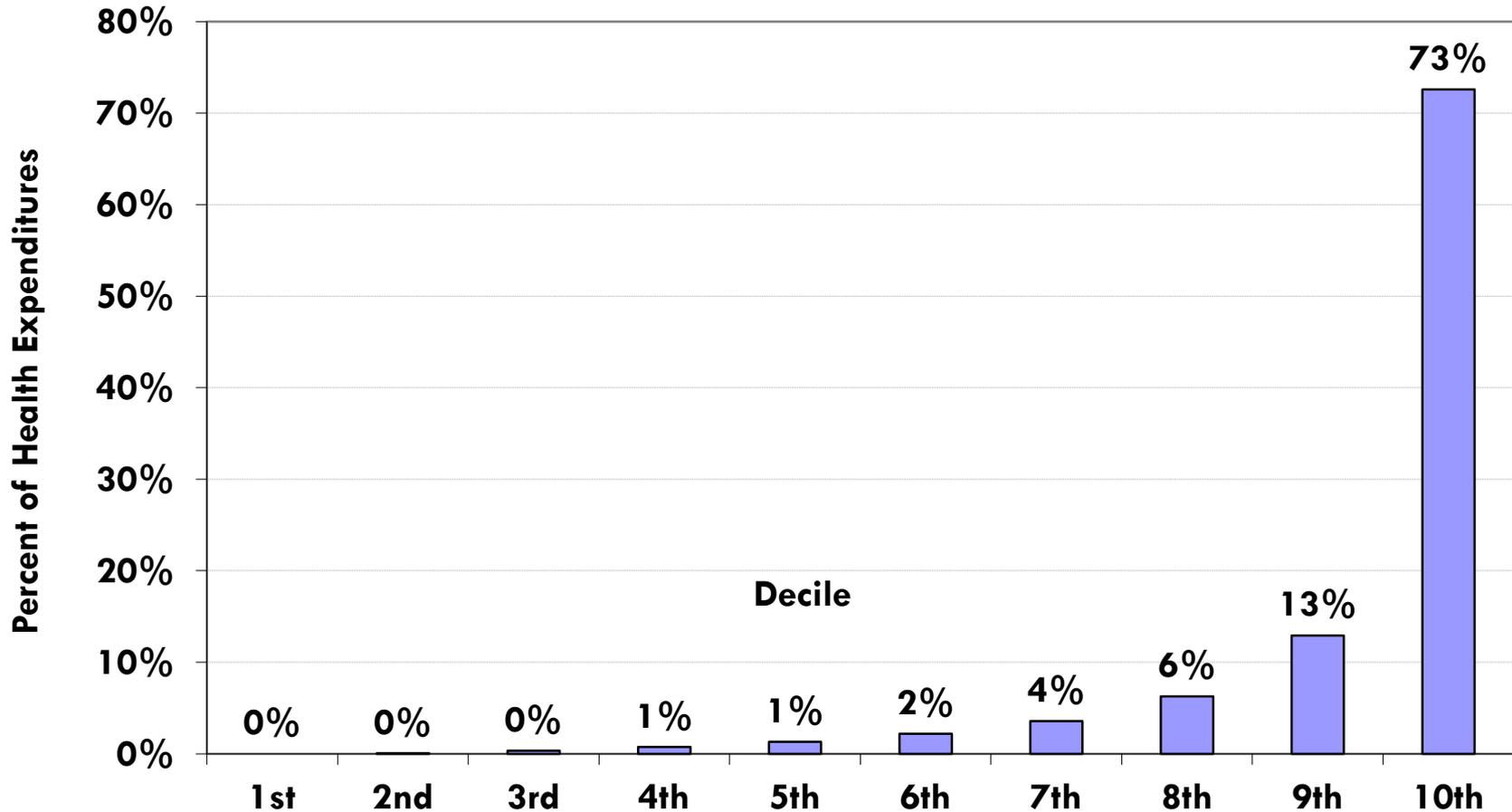
26

- Impact of revenue sources
 - ▣ Incidence of revenue streams
 - Wage earner contributions v. non-wage earner contributions
 - ▣ Revenue streams influence behavior
- The ability of the financing sources to sustain your health care priorities over time
- The impacts and fairness of financing on individuals
- The impacts on the business and provider communities
- Relationship between principles and funding sources

Funding Sources for Health Care Reform: Considerations (4)

27

Distribution of Health Expenditures in the U.S. Population



Least expensive 10%

Source: Agency for Healthcare Research and Quality / MEPS, 1999

Funding Sources: Health Care Reform Financing System

28

- Break out for small group discussions (25 minutes)
- Express your preference via the boxes

Small Group Discussion Question

29

- Focus the discussion with these questions around the circle:
- ***I believe that (funding source/mix of funding sources) reflects the principles I selected earlier because...***
- ***2. As an individual, provider, or business owner, I am most concerned with (funding source/mix of funding sources) because it...***
- Express your preference via the boxes

How Can Vermonters Stay Informed?

30

- Please check <http://hcr.vermont.gov/>
 - Up to date information
 - Encourage Vermonters to participate in future sessions in person or online

- Thank you!

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APPENDIX C
HANDOUTS TO GUIDE SMALL GROUP ACTIVITIES AT HEALTH CARE REFORM
FINANCING LISTENING SESSIONS

HEALTH CARE REFORM FINANCING LISTENING SESSION
EXERCISE 1: PRINCIPLES OF HEALTH CARE REFORM FINANCING

The administration and legislature must make choices in health care finance, and those choices will be based on the prioritization of the principles. All of the following principles are legitimate considerations when structuring a reform of health care finance. In this exercise we are asking all Vermonters to consider the principles and choose which two or three are most important and which one or two are not as important in structuring health care finance.

ACT 48 PRINCIPLES FOR HEALTH CARE FINANCING SYSTEM

Act 48 Sec. 1a. Principle on financing: (11) The financing of health care in Vermont must be sufficient, fair, predictable, transparent, sustainable, and shared equitably.

PRINCIPLES TO CONSIDER

Equity

A financing system that is...

1. universal in paying for the health care coverage of all Vermonters
2. universal in participation of all Vermonters
3. progressive by taking into account ability to pay for coverage
4. uniform in placing similar burdens on individuals in similar circumstances

Stability

A financing system that is...

5. balanced with diverse revenue sources for reliable, sufficient funding that capitalizes on federal funds available for health care
6. simple for ease and efficiency in compliance and administration
7. transparent and accountable to Vermonters as payers, patients and providers
8. predictable with certainty for payers, patients and providers
9. sensitive to interstate and international economic pressures for Vermont businesses
10. non-disruptive with transitional provisions for Vermont individuals and businesses

Affordability

A financing system that is...

11. innovative with incentives for good health and disease management
12. encouraging of awareness of health care costs and appropriate elasticity of demand for health care services
13. supportive of the goal of paying providers the same regardless of payer so that there is no cost shift from public programs to the private insurance market
14. encouraging of providers relocating to Vermont

Small Group Exercise

Groups will gather in circles. Please choose a facilitator and note taker. Each participant should complete the following question the first time around the circle:

1. *(Fill in a chosen preferred principle) is important for health care finance reform because it...*

Complete the second question during the second time around the circle:

2. *(Fill in the least desired principle) is not so important for health care finance reform because...*

EXPRESS YOUR PREFERENCE

After discussion around the circle, participants should choose up to three preferred principles on a green card. Each participant should choose one least desired principle on a yellow card. These cards, collected here and at other forums around Vermont, will be used to provide public input about the principles that should guide the design of a health care finance system, principles that perhaps should be emphasized less, and principles that illustrate the difficulty of designing a system that is mutually agreeable to Vermonters.

HEALTH CARE REFORM FINANCING LISTENING SESSION
EXERCISE 2: HEALTH CARE REFORM FINANCING SOURCES

The administration and legislature must make choices in health care finance. In this exercise we are asking all Vermonters to consider the mix of funding sources described during the presentation and express preferences for the mix of funding sources that may be considered to fund a unified and universal health care system in Vermont.

Potential funding sources:

- INDIVIDUALS: BENEFICIARY PREMIUMS
- INDIVIDUALS: OUT OF POCKET SPENDING FOR SERVICES
- GENERAL TAX ON BUSINESSES
- PAYROLL TAX, BOTH BUSINESSES AND INDIVIDUALS
- INCOME TAX
- PROPERTY TAX
- CONSUMPTION TAXES
- OTHER

SMALL GROUP EXERCISE

Groups will gather in circles. Please choose a facilitator and note taker. Each participant should complete the following question the first time around the circle:

1. *I believe that (funding source/mix of funding sources) reflects the principles I selected earlier.*

Complete the second question during the second time around the circle:

2. *As an individual, provider, or business owner, I am most concerned with (funding source/mix of funding sources) because it...*

EXPRESS YOUR PREFERENCE

All meeting attendees are provided an envelope with \$1,000 of money (in \$100 denominations – 10 X \$100). There are boxes representing the non-federal and provider funding sources described during the presentation. After discussion around the circle, participants should put what they believe to be the proper allocation of their money into the boxes to fund Vermont's future health care program. The results, collected here and at other forums around Vermont, will be used to provide public input regarding the future health care finance system proposals to be presented in 2013.

FINAL NOTE

Thank you! Please check <http://hcr.vermont.gov/> for up to date information on health care reform. Also, please encourage Vermonters to participate in future sessions.

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APPENDIX D
DATA TABLES

Table 1A sets forth the principle preferences expressed by participants at the listening sessions. The table below tallies how many times a principle was placed by a participant on a green card. Participants were asked to list three principles that should be emphasized in the design of a health care financing system.

Table 1A: Policy Preferences

Principle	Burlington	Rutland	Brattleboro	St. Johnsbury	TOTAL
1	48	24	20	15	107
2	44	34	20	18	116
3	48	30	34	19	131
4	11	4	2	2	19
5	24	10	12	4	50
6	13	9	4	4	30
7	22	10	9	6	47
8	9	5	5	0	19
9	13	8	4	0	25
10	10	5	0	5	20
11	48	24	23	2	97
12	12	9	7	0	28
13	8	8	8	0	24
14	15	9	3	0	27
TOTAL	325	189	151	75	740

Table 2A sets forth the principle to be deemphasized as expressed by participants at the listening sessions. The table below tallies how many times a principle was placed by a participant on a yellow card. Participants were asked to list one principle that should be deemphasized in the design of a health care financing system.

Table 2A: Policy Preference to be Deemphasized

Principle	Burlington	Rutland	Brattleboro	St. Johnsbury	TOTAL
1	2	11	0	0	13
2	8	4	1	0	13
3	11	4	0	0	15
4	6	4	3	6	19
5	3	4	2	0	9
6	4	0	1	0	5
7	4	1	0	1	6
8	2	2	3	0	7
9	30	6	19	6	61
10	9	2	7	1	19
11	1	5	2	0	8
12	11	6	4	2	23
13	7	2	2	1	12
14	9	6	8	1	24
TOTAL	107	57	52	18	234

Tables 1A and 2A were created by tallying by hand the green and yellow cards submitted by participants at each listening session. During this tally, staff placed an identification number on each card, starting a new series for each listening session. For example, each listening session would have a green and yellow card labeled 1. Tables 3A-6A on the foregoing pages show the results of the small group exercises for each listening session by card.

It is important to note that variations occurred on the cards submitted by the general public. Some participants listed fewer than three preferences on their green card. In this case, the table entry is left blank. Some participants listed more than three principles. In this case, only the first three listed were tallied. Some participants submitted cards that did not contain principle preferences, either stating that all principles are important or submitting non-germane comments. These table entries are left blank. Lastly, it is important to note that fewer yellow cards were submitted than green cards.

Table 3A: Burlington Green and Yellow Card Tally

Burlington					
ID#	GREEN CARD PRINCIPLE 1	GREEN CARD PRINCIPLE 2	GREEN CARD PRINCIPLE 3	ID#	YELLOW CARD PRINCIPLE
1	9	14		1	9
2	2	3	8	2	12
3	2	3	8	3	14
4	1	3		4	4
5	2	9	11	5	3
6	2	3	7	6	9
7	1	2	3	7	9
8	1	3	7	8	9
9	9	12		9	12
10	2	3	11	10	9
11	1	2	3	11	2
12	1	3	7	12	
13	1	2	3	13	
14	7	12	10	14	
15				15	2
16	2	11	5	16	
17	2	1	3	17	14
18	2	3	7	18	
19	12	5	4	19	10
20	2	9	11	20	9

ID#	GREEN CARD PRINCIPLE 1	GREEN CARD PRINCIPLE 2	GREEN CARD PRINCIPLE 3	ID#	YELLOW CARD PRINCIPLE
21				21	10
22	3	7	1	22	9
23	1	2	5	23	14
24	2	4	6	24	12
25				25	6
26				26	14
27				27	7
28	3	2	1	28	10
29	5	12		29	9
30	2	8	13	30	9
31	4	1		31	10
32	1	2	3	32	8
33	14			33	9
34	1	2	3	34	10
35	3			35	1
36	11	14	7	36	4
37	1	3	7	37	3
38	10			38	13
39	11	7	14	39	12
40	4	11		40	12
41	11	2	5	41	4
42	2	14	7	42	8
43	5			43	1
44	2	8	11	44	14
45	14	8	4	45	9
46	1	3	8	46	13
47	14	10		47	13
48	2	11	5	48	9
49	1	5	10	49	9
50	11	9	12	50	9
51	1	2	3	51	12
52	1	2	9	52	7
53	1	11	3	53	14
54	1	2	11	54	
55	1	5	11	55	7
56				56	7
57	1	7	13	57	4
58	13	11		58	14
59	1	2	3	59	9
60	11	13	2	60	10
61	6	10		61	3

ID#	GREEN CARD PRINCIPLE 1	GREEN CARD PRINCIPLE 2	GREEN CARD PRINCIPLE 3	ID#	YELLOW CARD PRINCIPLE
62	9			62	9
63	3	2	10	63	12
64	10	6	9	64	9
65	10	6	12	65	12
66	2	3	5	66	11
67	1	2	3	67	9
68	6			68	9
69	1	4		69	9
70	5			70	10
71	5	9	11	71	9
72	1	3	13	72	10
73	11	12	8	73	3
74	3	7	11	74	9
75	3	6	7	75	3
76	3	7	11	76	
77	3	11	14	77	12
78	1			78	2
79	7	5		79	2
80	11	3		80	9
81	7	11		81	9
82	11			82	
83	1	2	3	83	
84	3	5	11	84	3
85	2	8	13	85	3
86	1	2	3	86	9
87	2	5	11	87	10
88	1	3	7	88	
89	3	11	5	89	6
90	1	6	7	90	6
91	11	8	3	91	6
92	5	11		92	14
93	11			93	3
94	3			94	4
95				95	
96				96	2
97				97	2
98	1	3	7	98	2
99	1	2		99	5
100				100	3
101	3	5	14	101	12
102				102	12

ID#	GREEN CARD PRINCIPLE 1	GREEN CARD PRINCIPLE 2	GREEN CARD PRINCIPLE 3	ID#	YELLOW CARD PRINCIPLE
103	1			103	3
104	1	2	12	104	9
105	1	4	11	105	9
106	2	5	12	106	5
107	2	9	11	107	13
108	1	2	3	108	9
109	10	14	1	109	
110	5			110	14
111	5	7	11	111	5
112	11			112	4
113	11	1	13	113	
114	11	12	2	114	2
115	11	4	12	115	13
116	11	4		116	13
117	11			117	9
118	11			118	3
119	4			119	13
120	1	5	3		
121	2	14			
122	3				
123	3	14	11		
124	2	3	4		
125	13	3	11		
126	14	11	2		
127	9				
128	1	2	6		
129	6	9	14		
130	1	6	5		
131	6	1	14		
132	10	9	6		
133	3				
134	1	3	11		
135	1	11	7		
136	1	6	11		
137	1	5	11		
138	1	2	7		
139	12	11			

Table 4A: Rutland Green and Yellow Card Tally

Rutland					
ID#	GREEN CARD PRINCIPLE 1	GREEN CARD PRINCIPLE 2	GREEN CARD PRINCIPLE 3	ID#	YELLOW CARD PRINCIPLE
1				1	3
2	3			2	
3	2			3	9
4	3	8	11	4	13
5	5			5	3
6	5			6	11
7	5	2	10	7	
8	2	11	14	8	11
9	11			9	3
10	1	2	3	10	4
11	2	12	14	11	9
12	2	13	6	12	9
13	2	3		13	9
14	3	7		14	12
15	2	4		15	14
16	11	14	8	16	13
17	1	5	10	17	11
18	3	14		18	14
19	12			19	1
20	3			20	14
21	4	7	13	21	14
22	1	2	13	22	
23	11			23	9
24	7	11		24	9
25	14	11	6	25	
26	3	6	1	26	1
27	1	2	8	27	
28	2			28	7
29	3	5	4	29	
30	6			30	30
31	1			31	12
32	2			32	11
33	3	13		33	5
34	2	12	9	34	8
35	9	3	13	35	1
36	9	12	14	36	1

ID#	GREEN CARD PRINCIPLE 1	GREEN CARD PRINCIPLE 2	GREEN CARD PRINCIPLE 3	ID#	YELLOW CARD PRINCIPLE
37	11	9	3	37	3
38	11			38	5
39	1	3	10	39	
40	9	10		40	10
41	3			41	4
42	1	2	3	42	1
43	7	14	8	43	1
44	3	11	13	44	1
45	3			45	
46	1	3	5	46	
47	14	12	8	47	1
48	10			48	12
49				49	2
50	2	5		50	1
51	2			51	2
52	3	11		52	14
53	1	2	5	53	1
54	1	3	6	54	8
55	1	2	11	55	10
56	3	11	2	56	1
57	2	12		57	4
58	7	12		58	12
59	11	9		59	12
60	1	2	11	60	5
61	11	12	3	61	14
62	1	2	11	62	5
63	2			63	11
64	11			64	2
65	3	5	6	65	2
66	1	2	3		
67	9				
68					
69	1	2	7		
70	3				
71	1	3	6		
72	1	2	3		
73	1	2			
74	1	2			
75	1	11	9		
76	2	13			
77	3	1	13		

ID#	GREEN CARD PRINCIPLE 1	GREEN CARD PRINCIPLE 2	GREEN CARD PRINCIPLE 3	ID#	YELLOW CARD PRINCIPLE
78	2	11			
79	5	11	14		
80	11				
81	6	7			
82	3	7	4		
83	2	12	7		
84	2	11	6		
85	1	3			
86	11	2	7		
87	2				
88	1				

Table 5A: Brattleboro Green and Yellow Card Tally

Brattleboro					
ID#	GREEN CARD PRINCIPLE 1	GREEN CARD PRINCIPLE 2	GREEN CARD PRINCIPLE 3	ID#	YELLOW CARD PRINCIPLE
1	2	7		1	14
2	2	11		2	
3	13	11	12	3	10
4	7	12		4	
5	11	1	7	5	
6				6	9
7	11	2		7	12
8	1	3	6	8	14
9	4	5	9	9	9
10	1	3	7	10	14
11	1	2	3	11	9
12	13	2	6	12	10
13	7	8		13	9
14	11			14	9
15	11	12		15	14
16	11	12		16	
17	9	12	14	17	9
18	4	8	12	18	10
19	3			19	10
20	3	11	13	20	14
21	1	3	5	21	9
22	11	2	3	22	9
23	1	2	3	23	8
24	7	12		24	9
25	3	8		25	11
26	2	7	8	26	11
27	1	3	5	27	8
28	1	2	3	28	14
29	1	2	3	29	12
30	2	3		30	9
31	3	11		31	2
32	3			32	14
33	1	3		33	9
34	11			34	9
35	3	2	1	35	12
36	5	11	13	36	9

ID#	GREEN CARD PRINCIPLE 1	GREEN CARD PRINCIPLE 2	GREEN CARD PRINCIPLE 3	ID#	YELLOW CARD PRINCIPLE
37	11			37	13
38	2	1	3	38	10
39	3	2	1	39	9
40	1	2	6	40	9
41	11	3	5	41	10
42	9	5		42	9
43	1	2	3	43	12
44	3	11	13	44	10
45	3			45	9
46	3			46	8
47	3			47	13
48	11			48	14
49	3	7	5	49	4
50	3	14	6	50	5
51	11	1	9	51	5
52	3	11		52	4
53				53	9
54	3	8	11	54	4
55	11	5	1	55	9
56	1	2	3	56	
57	13			57	6
58	5	11	14		
59	1	2	3		
60	1	2	3		
61	11	13	3		
62	3	2	7		
63	5	11	13		
64	5				
65	5				

Table 6A: St. Johnsbury Green and Yellow Card Tally

St. Johnsbury					
ID#	GREEN CARD PRINCIPLE 1	GREEN CARD PRINCIPLE 2	GREEN CARD PRINCIPLE 3	ID#	YELLOW CARD PRINCIPLE
1	3	2	8	1	4
2	2	7	13	2	9
3	2	3	11	3	4
4	1	2	3	4	9
5	1	2	3	5	9
6	1	3		6	
7	2	3		7	13
8				8	14
9	1	2	3	9	4
10	1	2	3	10	
11	3	7		11	7
12	1	6	11	12	10
13	1	5	8	13	9
14	1	3	7	14	4
15	1	2	3	15	4
16	2	4	13	16	
17	1	2	4	17	9
18	4	5	6	18	4
19	1	3		19	9
20	1	2	3	20	12
21				21	12
22	2	3	11	22	NA
23	2	3	4		
24					
25	1	2	6		
26	3	1	7		
27	3	2	8		
28	2	6	11		
29	3	7	11		
30	1	2	3		

Table 7A sets forth the funding source preferences expressed by participants at the listening sessions. All meeting attendees were provided an envelope with \$1,000 of money (in \$100 denominations – 10 X \$100). The table below tallies how many of those bills were placed in the receptacle for each potential funding source.

Table 7A: Funding Source Preferences

	Burlington	Rutland	Brattleboro	St. Johnsbury	Total
Income Tax	519	245	205	127	1096
Consumption Tax	214	143	141	31	529
Individual Premiums	141	96	81	23	341
Payroll Tax	133	106	32	36	307
Individual Out of Pocket	68	93	59	9	229
General Business Tax	93	32	53	48	226
Other	84	56	31	11	182
Property Tax	27	30	38	13	108
	1279	801	640	298	3018