



State of Vermont
Agency of Administration
Health Care Reform
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Benefit Design in Green Mountain Care: Summary of the Spring 2012 Listening Sessions

November 28, 2012

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I. Introduction

During the spring of 2012 the Agency of Human Services (AHS) and the Agency of Administration (AOA) engaged in a series of listening sessions around the state to gather public input on health care benefit design in Vermont's future single-payer health care system, Green Mountain Care. Green Mountain Care was created in 2011 with the passage of Act 48, but it is still in the planning phase and will not go into effect until certain requirements, as outlined in the law, are met.

One of the requirements of Act 48 is a comprehensive benefit package for all Vermonters. Health benefits, in the context of health insurance today, are both "what we get" and "what we pay" through private insurance coverage or public programs (like Medicaid). Benefits include covered health services, premiums, and cost-sharing (for example, deductibles or co-payments).

The listening sessions were an opportunity for the public to express preferences that will help shape the benefit design in the new unified system. In Act 48, the importance of public input was recognized by the legislature in the language of the bill:

The state must ensure public participation in the design, implementation, evaluation, and accountability mechanisms of the health care system.

Benefit design in the Green Mountain Care single-payer system provides an opportunity for creative and innovative changes to the way “benefit packages” are designed today in traditional private health insurance companies and public health care programs.

There is a lot of activity happening with health care reform right now on both the state and the federal level, so the listening sessions were also an opportunity for public outreach and education on reform implementation in Vermont. Planning for Green Mountain Care is happening at the same time the state is planning for implementation of the Vermont Health Benefit Exchange, which is guided by the federal Affordable Care Act. For the purpose of this series of listening sessions it was important to make the distinction that the sessions were intended to gather input on the benefit design for the future single-payer system, not the benchmark benefit package required for the Exchange. The benchmark plan for the Exchange is shaped by federal law, whereas the plan for single-payer will be implemented only after Vermont obtains a federal waiver that will allow for more state control and innovation. This will not happen until after the Exchange is implemented in 2014. Please view the listening session slide presentation for background information on the Exchange and the general health care reform implementation timeline (Appendix A).

In addition to the series of listening sessions, AOA and the Green Mountain Care Board jointly hosted a formal public hearing where health care professionals, patient advocates, and members of the public were invited to provide two minutes of verbal testimony, or submit written testimony, for the benefit of the administration and the board. Written comments are posted on the AOA health care reform website at http://hcr.vermont.gov/public_engagement/benefits.

II. Goals of the Listening Sessions

The goals of the benefits listening sessions were to reach out and engage the public in the process of health care reform implementation and gather feedback from the public on their hopes, fears, priorities and ideas for comprehensive health care coverage under a single-payer system.

III. Schedule of the Listening Sessions

April 25 – Brattleboro, Marlboro College Grad Center

May 2 – Burlington, City Hall Contois Auditorium

May 8 – Rutland Free Library, Fox Room

May 31 – Public Hearing held at 11 VIT video-conferencing sites around the state

June 7 – St. Johnsbury, Catamount Arts
June 13- Bennington, Firehouse
June 20 – White River Junction, Hartford High School

IV. Development of the Listening Sessions

After receiving positive feedback on the format of the financing listening sessions that took place last winter, AHS and AOA decided to use a similar format of informal small group discussions and exercises. To develop the content, AHS and AOA consulted with other state agencies, including members of the Green Mountain Care Board, and health care advocates. The sessions were informal meetings alternating between information presented by the Director of Health Care Reform and small group exercises and discussions led by participants.

The listening sessions were divided into three components:

- 1) *Information* - Health care reform implementation timeline and background information to frame discussion on benefit design.
- 2) *Exercise #1* - Gathering open-ended feedback on hopes and fears from the public surrounding benefits and the single-payer system.
- 3) *Exercise #2* - Setting priorities and examining the boundaries and limitations of a publicly financed system.

The two small group discussions lasted about twenty minutes each. A number of state officials and staff working closely on health care reform were present at each session to circulate among the small groups and listen to participant feedback. They included: Secretary and Deputy Secretary of the Agency of Human Services, Director of Health Care Reform in the Agency of Administration, Commissioner of the Department of Vermont Health Access (DVHA), Commissioner of the Vermont Department of Health, Deputy Commissioner of Health Care Administration at the Department of Financial Regulation, and members of the Green Mountain Care Board.

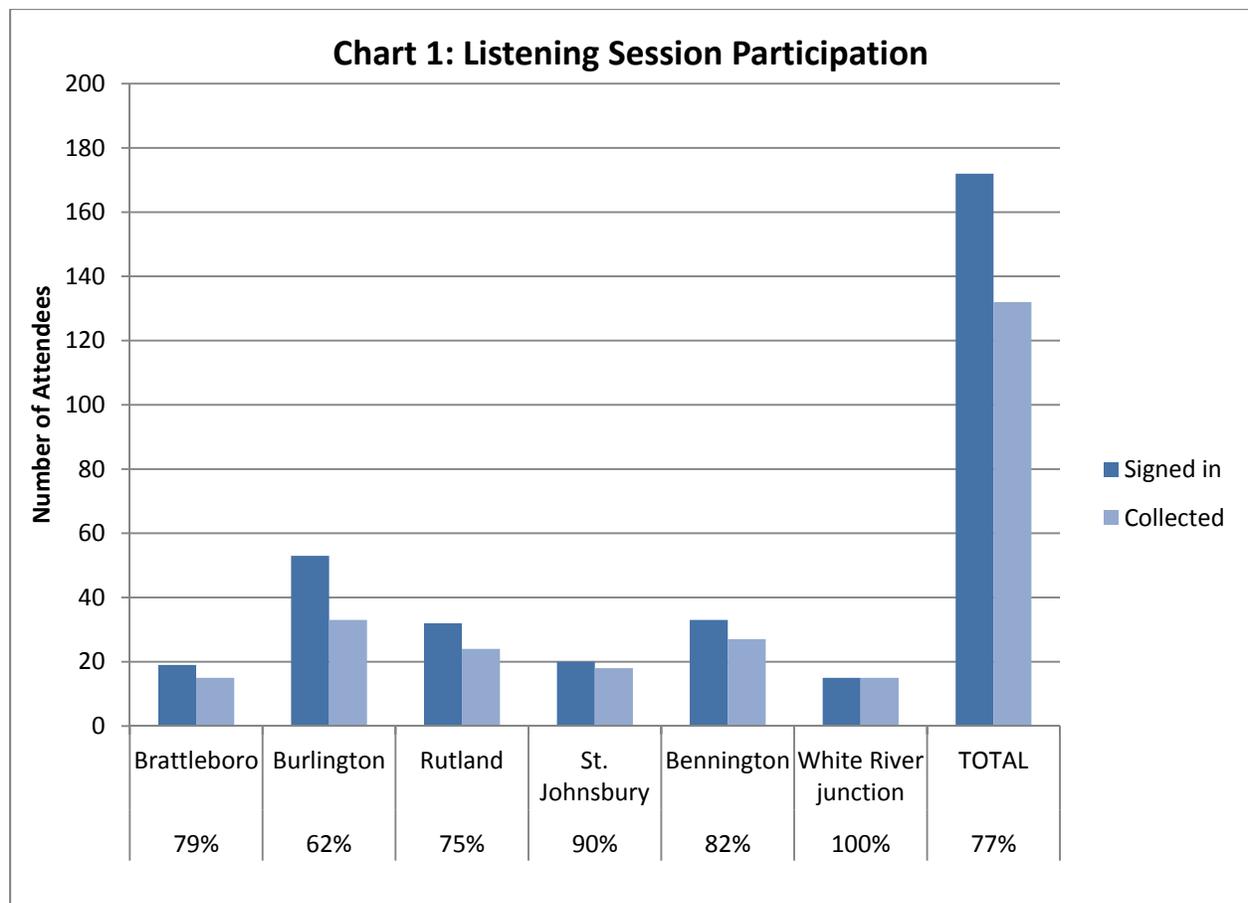
To publicize the listening sessions AOA sent out press releases at three different intervals to newspapers and other media sources around the state announcing the sessions and posted the releases on the AOA health care reform website. AOA also sent emails to legislators, advocates, and the DVHA Exchange Advisory Board to reach stakeholders and interested parties directly.

V. Summary of Input Collected

Participants were a self-selecting group who chose to participate in a health care reform public meeting on a spring evening. The methodology of collecting and analyzing input was not intended to be scientific. This summary is therefore an interpretation of a limited and self-selected sampling from around the state. There were a few comments from participants regarding attendance at the meetings, including some who felt there was not enough publicity

and not enough people were aware of the meetings, there was not enough outreach to attract people who were not already interested or involved in health care reform, there were conflicting meetings the same evening, or the meetings were difficult to access for parents with young children. Given the limitations, the meetings were generally well attended with about 15-33 participants in the smaller cities and about 53 participants in Burlington. About 172 people attended the sessions in total. It was evident that the Healthcare is a Human Right Campaign organized a visible group to attend each session.

Chart 1 illustrates participation at the listening sessions. The % represents the number of exercises collected out of the total number of participants who signed in at each location. We did not collect any other demographic information about participants other than the location they attended, but there appeared to be a wide range of ages from young adults in their 20s to adults over 65. A few younger children and at least one teen attended with a parent.



The focus of the sessions was to collect input on benefit design, which is generally understood to mean “what the health plan will pay for when you go to a health care provider.” Public and individual cost and cost-sharing was therefore necessarily part of the discussion. However, the framework and focus of the discussion was to hear about the health care needs of individuals and their communities and how a unified, public health care system could meet those needs.

Two overarching themes emerged from the discussions and feedback: 1) Everyone should be covered and 2) Everyone should be accountable.

Most participants agreed that it is important to cover all Vermonters. No one should be left out because of their inability to pay, employment status, health status, marital or family status, age or other life situation. Everyone needs access to routine wellness and prevention services because health care should focus on improving health and staying healthy. Everyone is included because everyone uses the health care system at some point their lives.

Most participants agreed that it is important for all Vermonters to be accountable. All Vermonters should be expected to pay for the health care plan in some way. Financing mechanisms and cost-sharing structures must be income sensitive and carefully designed not to inhibit needed care and services, especially primary, preventive, and chronic care. Accountability also means caring for the wellbeing of all Vermonters. Individuals and families are accountable for their own health; doctors and third-party payers are accountable for the health outcomes of patients and customers; state government is accountable for improving the health of the population and containing costs; and the population as a whole is accountable for the social, economic, and environmental factors affecting the health of Vermonters.

Exercise 1: Hopes & Fears

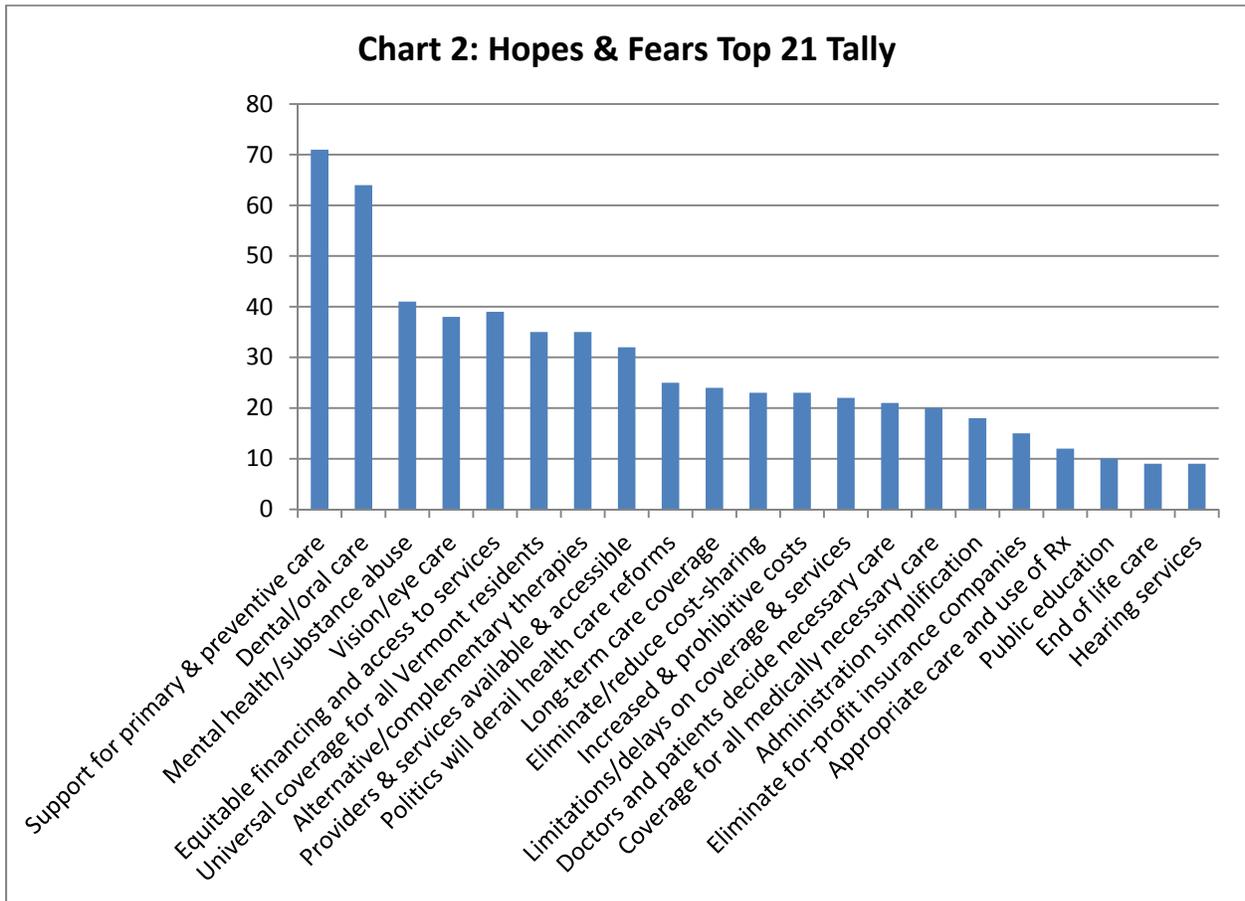
Input was collected at the sessions through two separate exercises. The first, “My Hopes & Fears” (Appendix B), provided participants with three definitions of *medical necessity* and four questions to help frame a group conversation around what kind of care is essential to individuals and communities and how accessible those services are in Vermont communities.

In addition to the group discussion, participants were asked to fill out two cards with their open-ended responses as part of this exercise. On one card they were asked to write down hopes for the new universal health care system. On the other card they were asked to write down fears about the universal system. Participants were then asked to turn in their cards.

To analyze the data staff read through the cards and tallied the different kinds of responses. Because hopes and fears were often two sides of the same coin (i.e., “my hope is that all Vermonters will have comprehensive coverage that they can afford; my fear is that the new system will not be accessible and affordable for everyone”) the responses were tallied all together rather than separating them into two separate tables for hopes and fears.

To illustrate the responses we highlighted the top twenty-one responses that appeared on the cards by graphing them according to frequency in Chart 2. Keep in mind that the cards were open-ended responses and participants were not given options to choose from, so there was a degree of interpretation when we tallied the responses. The tallied responses on the chart were worded to reflect how they appeared most frequently on the cards and are not direct quotes from participants. The top five responses were:

1. Support for primary and preventive care
2. Dental/oral care
3. Mental health and substance abuse services
4. Vision/eye care
5. Equitable financing and access to services



The focus of the sessions was on how to implement benefits in the new system passed into law in Act 48 and for the most part discussion stayed away from participants' viewpoints of the law itself. However, the exercises still provided the opportunity to express critical views or fears about the law. Of the five most mentioned concerns critical of Green Mountain Care, three of them were in the top twenty-one.

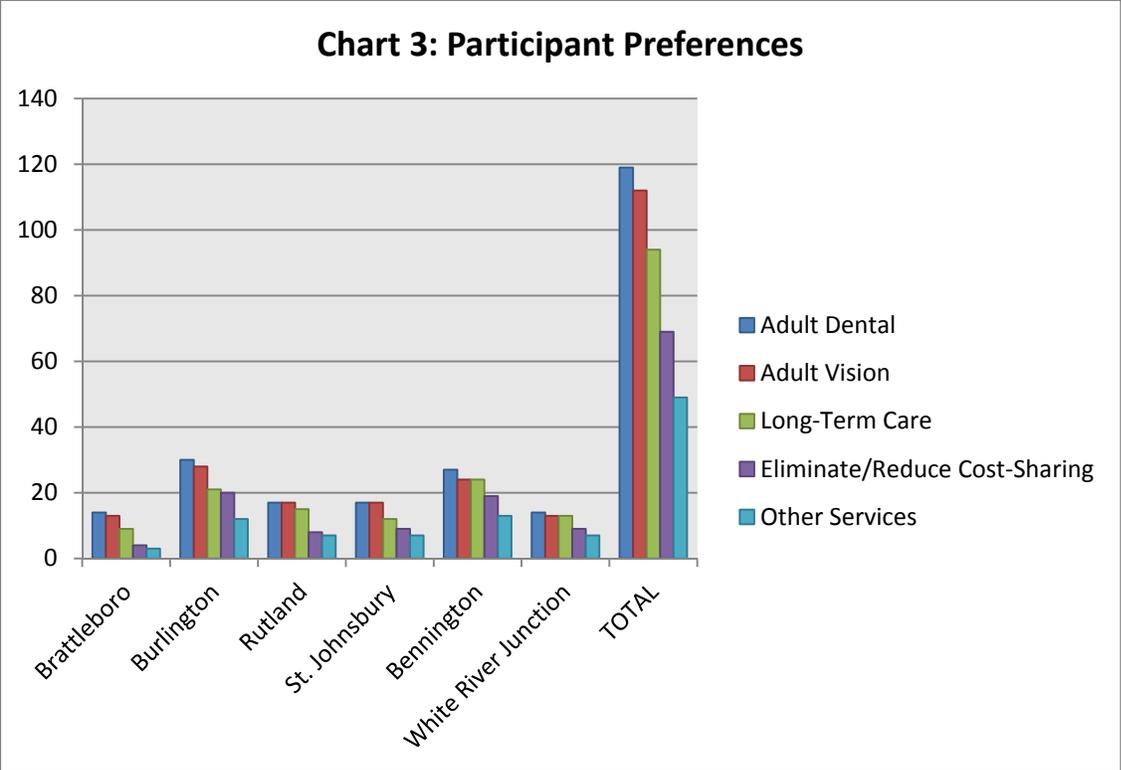
8. Accessibility of providers and services (i.e. concern that the new system will make providers and services less accessible)
12. Increased and prohibitive costs (i.e. economic feasibility of the plan, providing benefits we cannot pay for)
13. Limitations and delays on coverage and services
32. Concerns about competitive reimbursement to doctors (i.e. concern that doctors will leave the state)
42. Government/Board will make decisions about my health

These concerns were not so much about providing specific benefits or benefit design, but they were the most mentioned examples of concerns by participants at the listening sessions. The next exercise gave participants the opportunity to think about benefit design while taking these kinds of concerns into consideration.

Exercise 2: Preferences & Priority Setting

The second exercise, “Preferences & Priority Setting” (Appendix B) used a worksheet to ask participants to set priorities and examine the boundaries and limitations of a publicly financed system. The worksheet first explained to participants that there is a list of ten health care services that are considered essential under federal requirements for a waiver and under state law. These are required to be covered by the single-payer plan in Vermont. The services that participants were left to consider were additional services and often are not covered by standard major medical health insurance plans as we know them now. Most notably, these services are adult dental care, adult vision care, and long-term care. Some complementary forms of health care are also services that are not traditionally covered, and many participants considered or included these in their discussions and worksheets using the “other” boxes. In this exercise, participants were asked to consider these specific services for inclusion in a single-payer system. The exercise assigned a cost to each service and a budget for the system as a whole.

When asked which services participants would include in the new system given constraints, the same pattern was seen at each location around the state (see Chart 3). Overall, 90% of participants who turned in the exercise chose to include adult dental services. 85% chose to include adult vision, 71% included long-term care, 52% would design the system to reduce or eliminate cost-sharing, and 37% would use money to include “other services.” Keep in mind that participants were able to choose more than one option; they did not have to choose one option over the others. Presumably, participants chose not to include services as an attempt to prioritize and balance services with costs.

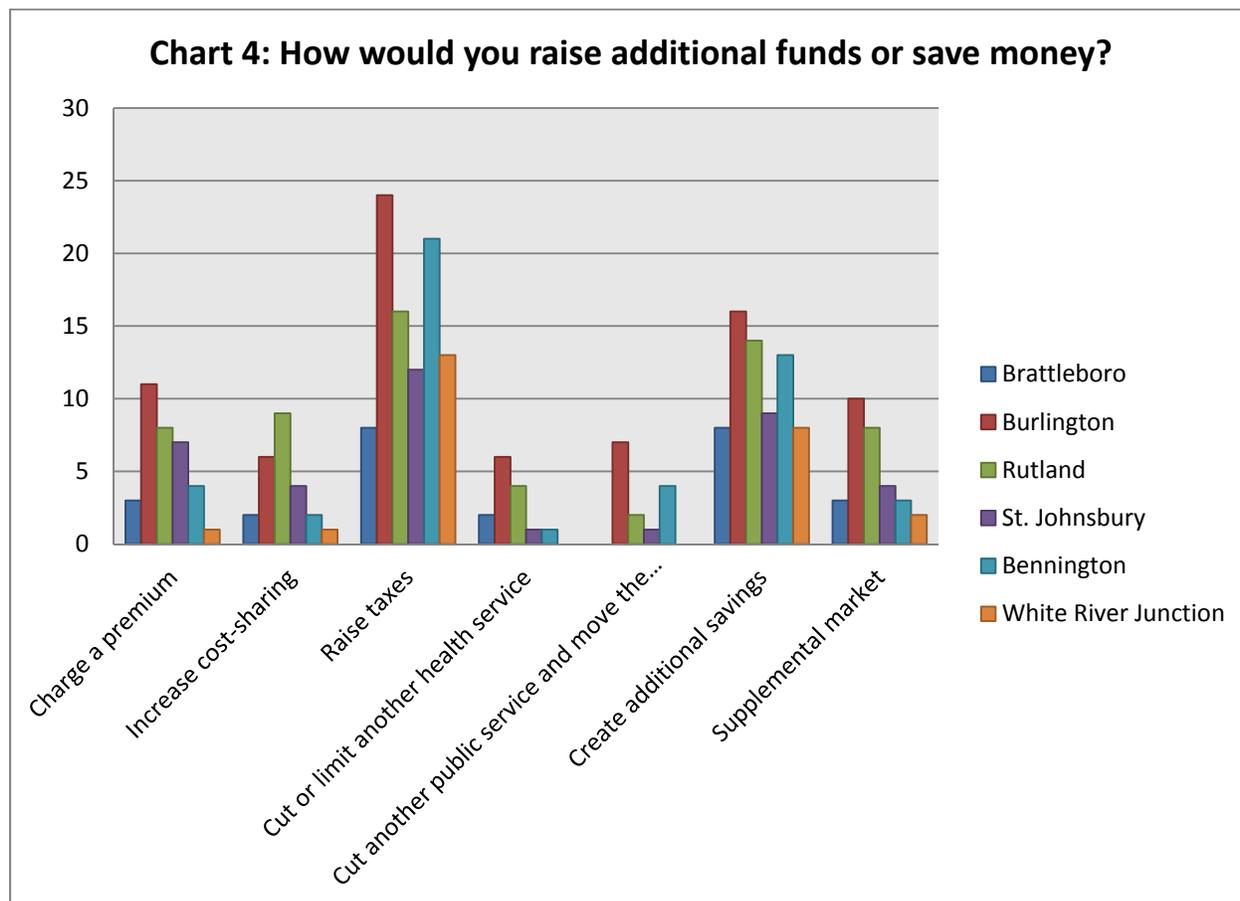


Participants were also asked to make choices about how to spend the money available to fund the system. In addition to including more or less services, participants had the choice to increase, eliminate, or reduce cost-sharing. If you spent more money than was available, the exercise asked you to choose how you would raise the money or save additional money to pay for services. The objective of the exercise was to examine choices given limited resources.

To the question, “how would you raise additional funds or save money?” the worksheet provided seven possible answers for participants to choose from and participants had the ability to fill in additional responses or explain their choice. The choices were 1) Charge a “premium” 2) Increase cost-sharing 3) Raise taxes 4) Cut or limit another health service 5) Cut another public service and move the money to health care 6) Create additional savings and 7) Create a supplemental insurance market where people could purchase coverage for additional services at an additional cost. Participants could choose more than one answer.

71% of participants who turned in their worksheets chose taxes as the means for raising the funds necessary to cover the costs of the system. Many qualified their choice by indicating what type of tax. Popular choices were (in no particular order) progressive income tax, payroll tax, tax on high earners and capital gains, and taxes on soda, cigarettes, or “junk” foods. Conversely, some suggested tax credits for “healthy habits.” Written responses frequently indicated that any tax used to fund the system should be progressive, fair and equitable, and reduce costs overall by bringing down premiums and other out-of-pocket costs individuals, families, and businesses are paying for health care now.

Finding ways to create additional savings within the system was also a popular choice with 52% of participants checking this box. 26% chose charging a premium, 22% would create a supplemental market where people could purchase additional coverage. 18% would increase cost-sharing and 11% would cut or limit another service or cut another public service and move the money to health care. Chart 4 illustrates a tally of the responses by location.



Open-ended responses to this question were allowed and many of the responses reflected similar cost-saving ideas to those that appeared in Chart 2 of this report. Top answers for creating additional savings included focusing on primary and preventive care, administrative simplification, reducing unnecessary care (i.e. “more care is not necessarily better care”), and payment reform to replace fee-for-service health care with a system that pays providers for improved outcomes. Other examples included end-of-life planning, legalization and taxation of marijuana, lottery income, reduction of military/defense spending, and reducing the prison population.

Only 22% chose to create a supplemental market. Supplemental markets are ubiquitous among universal health care systems in other countries so it is reasonable to conclude that participants were conflicted on the role of a supplemental market. Many considered it a good option for increasing services and tailoring coverage to the individual needs while keeping down public

costs. There were also many concerns that a supplemental market creates a two-tiered system where the most vulnerable people still do not have access to necessary services.

VI. Conclusion and Next Steps

The administration and state agencies charged with designing the benefits of Green Mountain Care will review public input received through various forums, including the listening sessions, public testimony, written testimony, advisory boards, and stakeholder meetings. A draft of the benefit design for Green Mountain Care will be part of the financing plan submitted to the legislature in January of 2013. Submitted public comments and links to video of the Burlington listening sessions and VIT hearing are posted online, as well as this report. Please visit the Agency of Administration health care reform website at this link: http://hcr.vermont.gov/public_engagement/benefits.

Green Mountain Care: Vermont's Health Care Reform



Benefits Listening Sessions May – June 2012

VERMONT HEALTH REFORM



Welcome!

- 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?

- 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
- Employers and the government will pay most of this cost, but we all will feel the economic effects
- Costs are not spread fairly & families risk bankruptcy because of health care debt

Why Health Care Reform?

- Plus, we don't cover everyone!
 - About 7% of Vermonters have no coverage
 - 200,000+ Vermonters are uninsured *or* underinsured

Underinsured = deductibles exceed 5% of family's income AND/OR total health care expenses exceed 10% of family income (5% if income below 200% of FPL).

- Risk of no insurance from job changes, divorce, other life changes
- In addition, despite being the healthiest state in the U.S., we could still do better.

Economic Consequences: Vermont Employers

- Between 1996 and 2006 the average annual premium for family coverage nearly doubled in constant dollars
- To keep up with the increase in total compensation (wages + benefits), employers have had to choose:
 - Reduce wage increases
 - Reduce the number of employees
 - Reduce the value of the insurance coverage
- These types of increases can cost Vermont jobs

Economic Consequences: Vermont Families

- Health care costs are rising, but Vermonters make, on average, about the same as they made a decade ago
- 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
- **Vermont's families and taxpayers pay more and more for less and less coverage**

Economic Consequences: Vermont Health Care Providers

- Current system means mounds of paperwork – the cost of interacting with insurers costs an estimated \$83,000 per year per physician in the U.S. – four times as much as in Canada
- Volume-driven revenues, even though more than half of VT docs are on salary
- Tremendous stress on primary care as patient evaluation and management doesn't pay
- Narrow margins for many hospitals

The Way Forward:

Health Care Reform as an Opportunity

- Implement a Vermont-style single payer system for insurance coverage – delink health insurance coverage from employment
- Reduce administrative waste
- Implement electronic medical records
- Pay providers for *value not volume*
- Improve care delivery
- Encourage Vermonters to be and stay as healthy as possible
- The legislature passed Act 48, which puts Vermont on track to implement a single payer system

Listening Session's Purpose

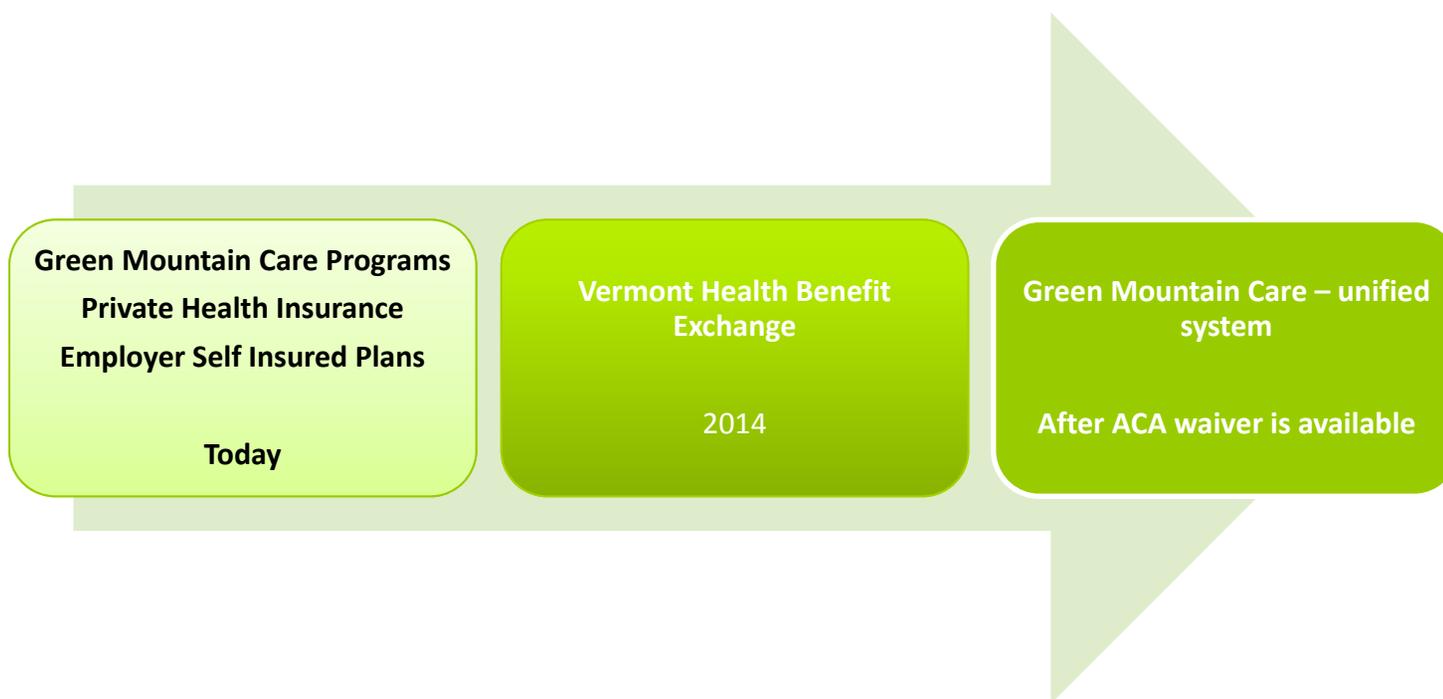
- Public input is important & necessary to inform the design of the benefits
- *“The state must ensure public participation in the design, implementation, evaluation, and accountability mechanisms of the health care system.” –ACT 48*
- Listening sessions provide an opportunity to express preferences that will help shape the benefits for Green Mountain Care

Organization of the Session

- Background
 - Timeline for Health Reform
 - Benefits Development
 - What are benefits?
 - Legal requirements
- Small Group Discussion
 - My Hopes and Fears
 - 20 minutes

- Preferences & Setting Priorities
 - Principles in Act 48
 - Connections between coverage and cost
- Small Group Exercise
 - Preferences
 - Priorities
 - 30 minutes

Health Care Reform Timeline



GREEN MOUNTAIN CARE

- The purpose of Green Mountain Care is to provide, as a public good, comprehensive, affordable, high-quality, publicly financed health care coverage for all Vermont residents in a seamless and equitable manner regardless of income, assets, health status, or availability of other health coverage. Green Mountain Care shall contain costs by:
 - (1) providing incentives to residents to avoid preventable health conditions, promote health, and avoid unnecessary emergency room visits;
 - (2) establishing innovative payment mechanisms to health care professionals, such as global payments;
 - (3) encouraging the management of health services through the Blueprint for Health; and
 - (4) reducing unnecessary administrative expenditures.



What has to happen before GMC implementation?

- Benefits must be designed
- Legislature must pass public financing mechanism and budget
- Green Mountain Care Board determines that Act 48 triggers are met:
 - (A) Each Vermont resident covered by Green Mountain Care will receive benefits with an actuarial value of 80 percent or greater.
 - (B) When implemented, Green Mountain Care will not have a negative aggregate impact on Vermont's economy.
 - (C) The financing for Green Mountain Care is sustainable.
 - (D) Administrative expenses will be reduced.
 - (E) Cost-containment efforts will result in a reduction in the rate of growth in Vermont's per-capita health care spending.
 - (F) Health care professionals will be reimbursed at levels sufficient to allow Vermont to recruit and retain high-quality health care professionals.

Exchange Benefits: limited state choices

As we know them now
(multiple plans; multiple insurers; state insurance mandates;)

Exchange plan design for 2014-2015
benchmark plan based on existing Vermont insurance plan; multiple plan designs; multiple insurers – driven by federal requirements

Exchange plan design for 2016
(waiting on federal guidance)

GMC Benefits: focus for today

As we know them now
(multiple plans)

Recommendations for
Green Mountain Care
modeling (2012)

Recommendations for
Green Mountain Care in
the future (after waiver)

GMC Benefits: Process in Act 48

- Benefits Listening Sessions – May – June 2012
- Secretary of the Agency of Human Services develops a recommendations
 - Cost out for financing plan due January 2013
- Presentation of recommendations to Green Mountain Care Board – Late fall 2012
- Green Mountain Care Board decides package to be used for financing plan – Late fall 2012
- Continued work on final benefits package by AHS 2013-2014
- Presentation of revised recommendations to Green Mountain Care Board
- Green Mountain Care Board decides revised package

WHAT ARE BENEFITS?



Benefits as we know them now

- Benefits are “what we get” through insurance coverage or public programs and are defined by:
 - Covered services – what services are paid for
 - Premium – monthly cost to have the insurance
 - Cost sharing – how much does the individual/family pay
 - Deductibles, co-payments, co-insurance
 - Utilization review – permissions needed from the insurer before you can get a specific service or drug
 - “Medical necessity”
- Again, some families no coverage

One Example: Medical necessity

- **IOM:** “...a condition of benefit coverage usually found in insurance contracts, allowing health insurers to review the appropriateness of any intervention a patient receives.”
(Usually with list of included and excluded services)
 - **Medical purpose:** preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms
 - **Scope:** type, frequency, extent, site, duration
 - **Evidence:** known to be effective ranging from scientific evidence to professional standards to expert opinion
 - **Value:** cost-effective for this condition compared to alternative interventions including no intervention

GMC Benefits: Act 48 Requirements

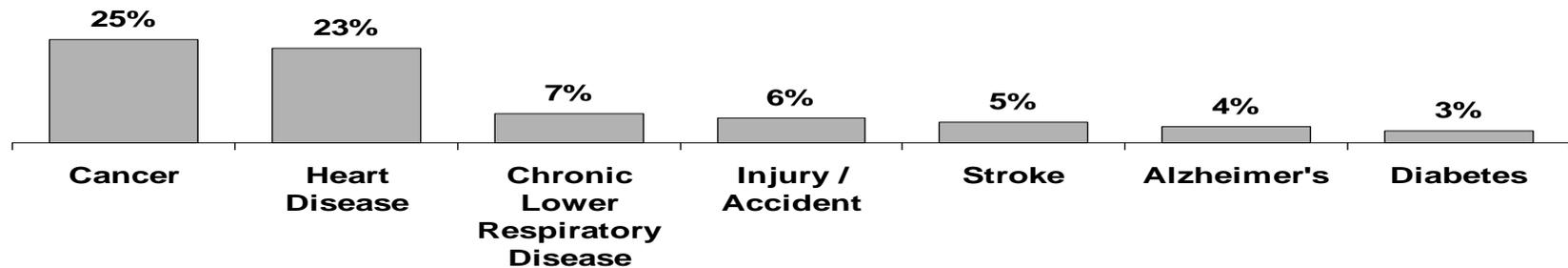
- Green Mountain Care means the public-private universal health care program designed to provide health benefits through a simplified, uniform, single administrative system (pursuant to 33 V.S.A Chapter 18, subchapter 2)
- Must include covered services equivalent to Catamount Health
 - Preventive care, primary care, acute episodic care, & hospital services
 - Must consider dental, vision, and long-term care
- Must ensure that cost-sharing is **at minimum** actuarially equivalent to at least 80% of the value of covered health services
 - Plan pays for 80%
 - Individual's deductible, co-payments, etc equals 20%

Leading Causes of Death

The three leading causes of death in Vermont are related to chronic disease. Nearly half of all deaths are caused by cancer or heart disease. Chronic lower respiratory disease is the third leading cause of death.

The fourth leading cause of death is not related to chronic disease – accidental injury accounts for about six percent of death in Vermont.

The fifth leading cause of death is stroke. Alzheimer’s and diabetes are responsible for slightly fewer deaths in the state.



VERMONT HEALTH REFORM

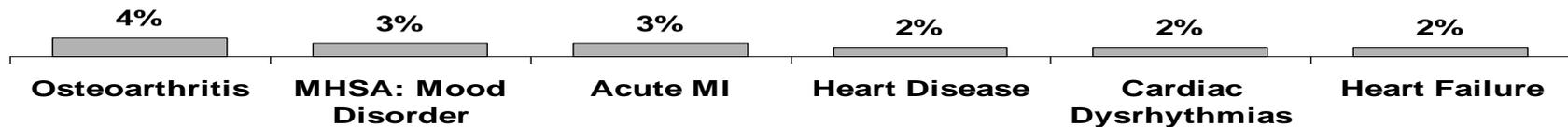


Leading Causes of Hospitalization – For Chronic Disease

The leading causes of chronic disease hospitalization are osteoarthritis, mental health or substance abuse, and cardiovascular disease-related.

Although osteoarthritis accounts for 4% of all hospitalizations in Vermont and, therefore is the ‘leading’ reason for chronic disease hospitalization, the third through sixth highest ranked reasons for hospitalization are related to cardiovascular disease. Taken together, these four causes make up 9% of all hospitalizations.

Mental health and substance abuse is indicated as the cause of 3% of hospitalizations.



VERMONT HEALTH REFORM

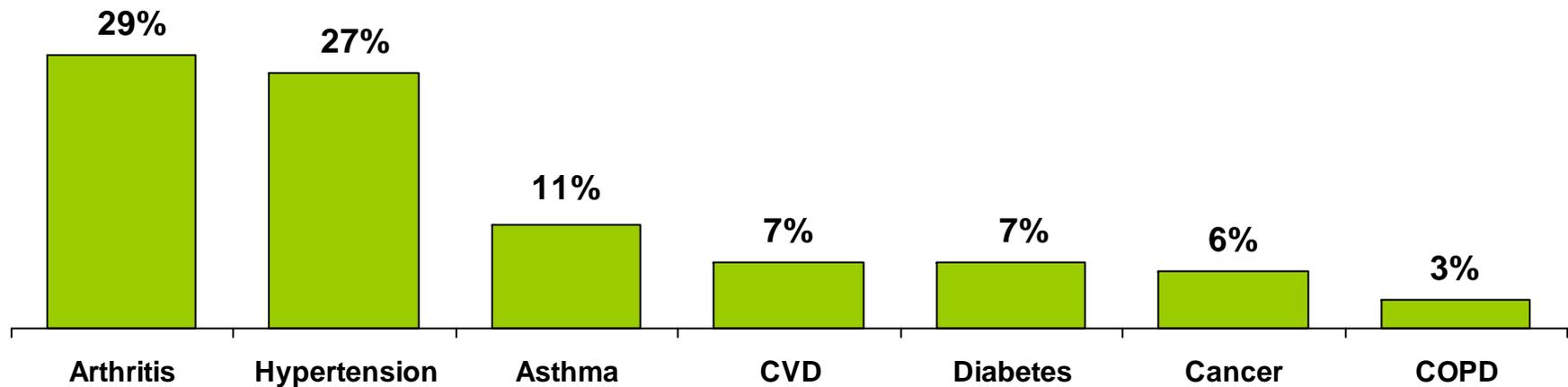


Chronic Disease Prevalence

Arthritis is the most common chronic disease in Vermont, followed closely by hypertension.

Asthma impacts approximately one in ten adult Vermonters.

Slightly fewer Vermonters have CVD, diabetes, or cancer. COPD effects 3% of the adult population.



VERMONT HEALTH REFORM



SMALL GROUP EXERCISE: MY HOPES & FEARS



PREFERENCES AND SETTING PRIORITIES

Principles in Act 48 re: benefits

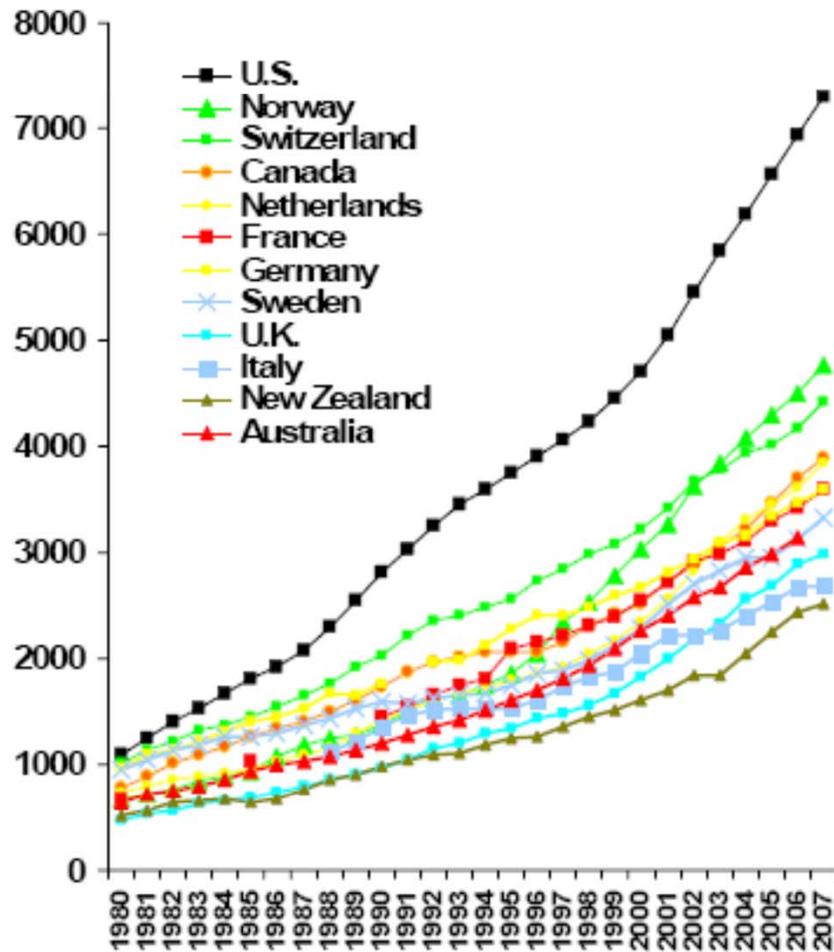
- The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers, such as cost, must not prevent people from accessing necessary health care. All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting.
- Overall health care costs must be contained and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care.
- Every Vermonter should be able to choose his or her health care providers.
- Vermonters should be aware of the costs of the health services they receive. Costs should be transparent and easy to understand.
- Individuals have a personal responsibility to maintain their own health and to use health resources wisely, and all individuals should have a financial stake in the health services they receive.

COVERAGE AND COST ARE CONNECTED

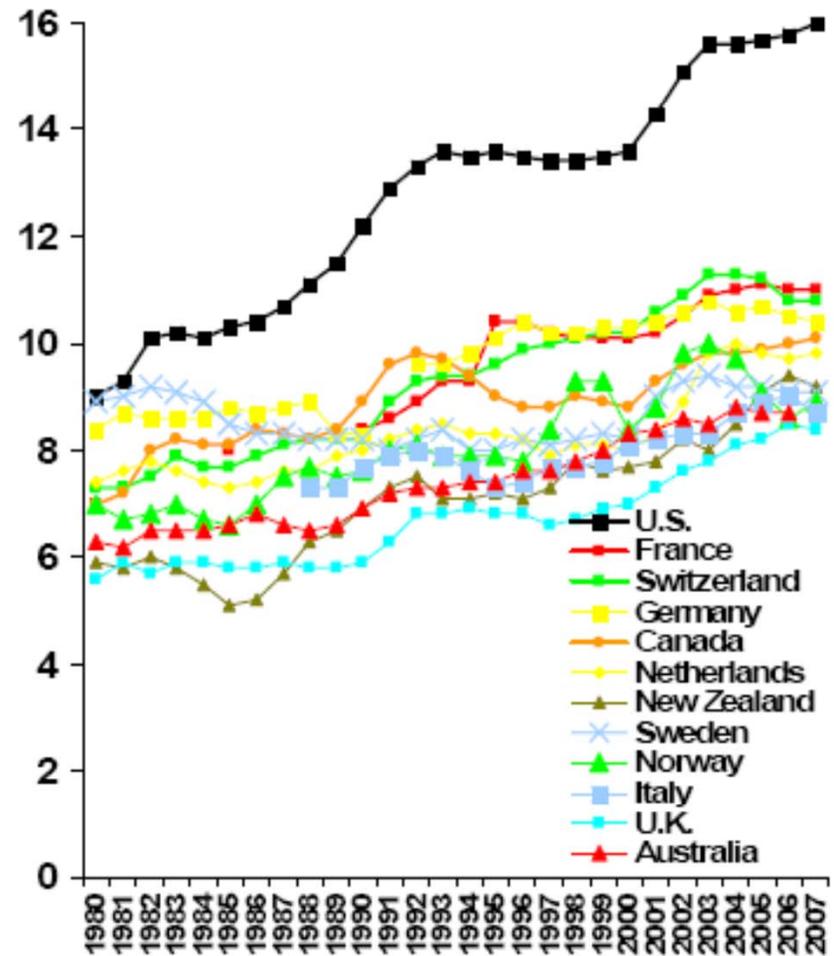
- In a universal system, everyone is covered and everyone pays into the system
- What are our priorities as a community? How do we decide what care to pay for?
 - While ensuring people get what they need
 - Promoting health and wellness

International Comparison of Spending on Health, 1980–2007

Average spending on health per capita (\$US PPP)



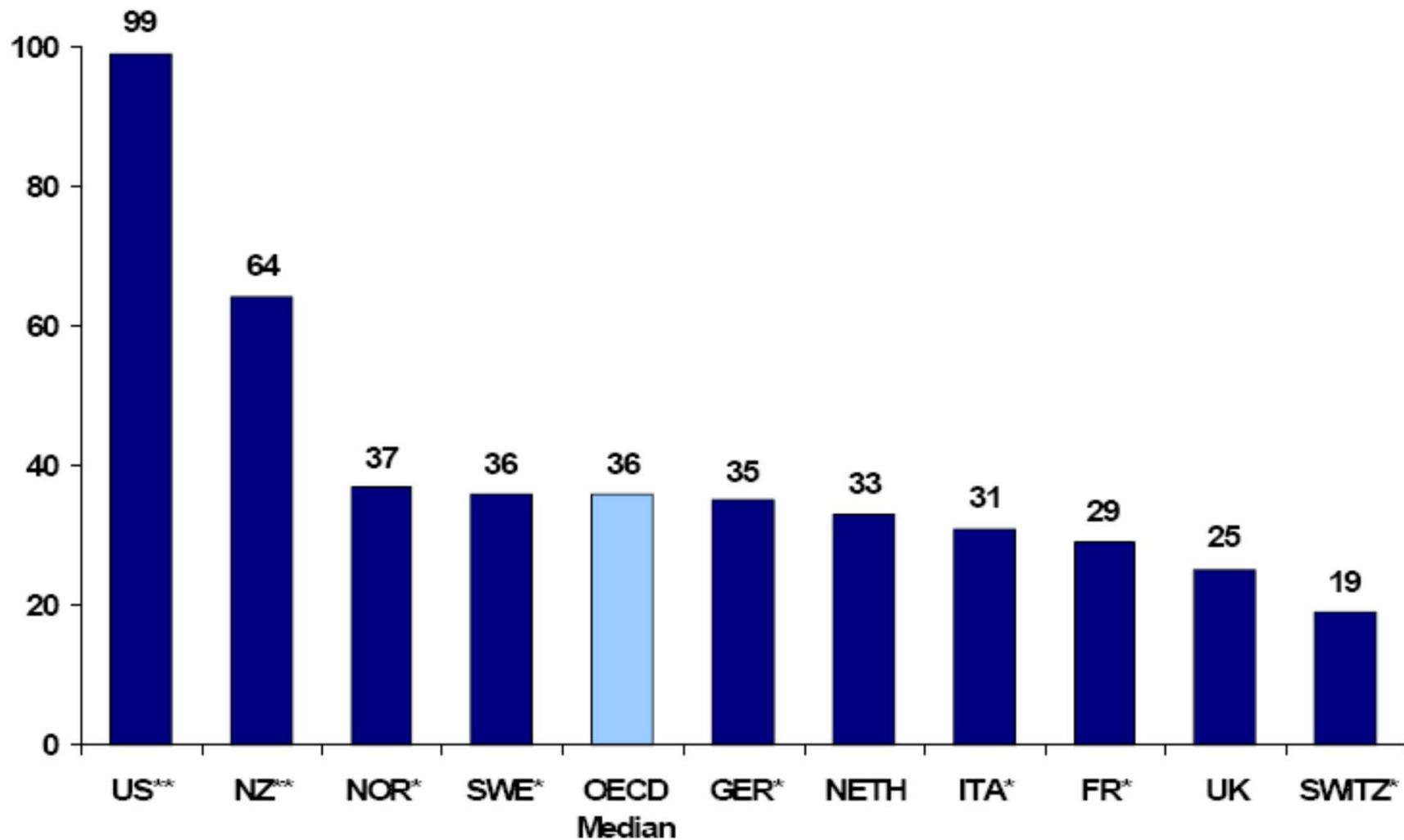
Total expenditures on health as percent of GDP



Source: OECD Health Data 2009 (June 2009).



Potential Years of Life Lost Because of Diabetes per 100,000 Population, 2007



* 2006

** 2005

Source: OECD Health Data 2009 (June 2009).



More is not always better in health care

- The traditional view that *more* care is always *better* care is changing.
- It is important to get what you *need* when you *need* it, but:
 - Evidence shows that there is “**unwarranted variation**” in health care – *in fact, the most famous study was in VT with tonsillectomies*¹
 - In multiple studies, it was shown that the **regions with the highest health care utilization often have worse outcomes** than regions with lower levels²
 - Studies report that **increased screening rates do not necessarily lead to decreased mortality**³

Table 3. Variation in number of surgical procedures performed per 10,000 persons for the 13 Vermont hospital service areas and comparison populations, Vermont, 1969. (Rates adjusted to Vermont age composition.)

Surgical procedure	Low-est two areas		En-tire state	High-est two areas	
Tonsillectomy	13	32	43	85	151
Appendectomy	10	15	18	27	32
Hemorrhoidectomy	2	4	6	9	10
Males					
Hernioplasty	29	38	41	47	48
Prostatectomy	11	13	20	28	38
Females					
Cholecystectomy	17	19	27	46	57
Hysterectomy	20	22	30	34	60
Mastectomy	12	14	18	28	33
Dilation and curettage	30	42	55	108	141
Varicose veins	6	7	12	24	28

Shift the Emphasis of Care

- In the US health care system there is not enough focus on and utilization of **preventative medicine and chronic disease management**, which improve health outcomes and curb escalating health costs
- Studies have shown that prevention can:
 - prevent chronic diseases (such as type II diabetes)
- Chronic disease management can:
 - prevent avoidable Emergency Dept visits, improve outcomes, prevent the need for invasive surgeries, save lives

The Three Categories of Health Care

- Evidence-based Care (about 12% of health care)
 - All with need should receive the same treatment
 - Clear treatment = clear positive outcome
- Preference-Sensitive Care (25% of health care)
 - Multiple treatment options, same or similar outcomes
 - Quality of life issues are main reason to pick one treatment over another
- Supply-Sensitive Care (63% of care)
 - More capacity means more is done
 - No evidence that more care improves health outcomes

Cost-sharing matters: research shows...

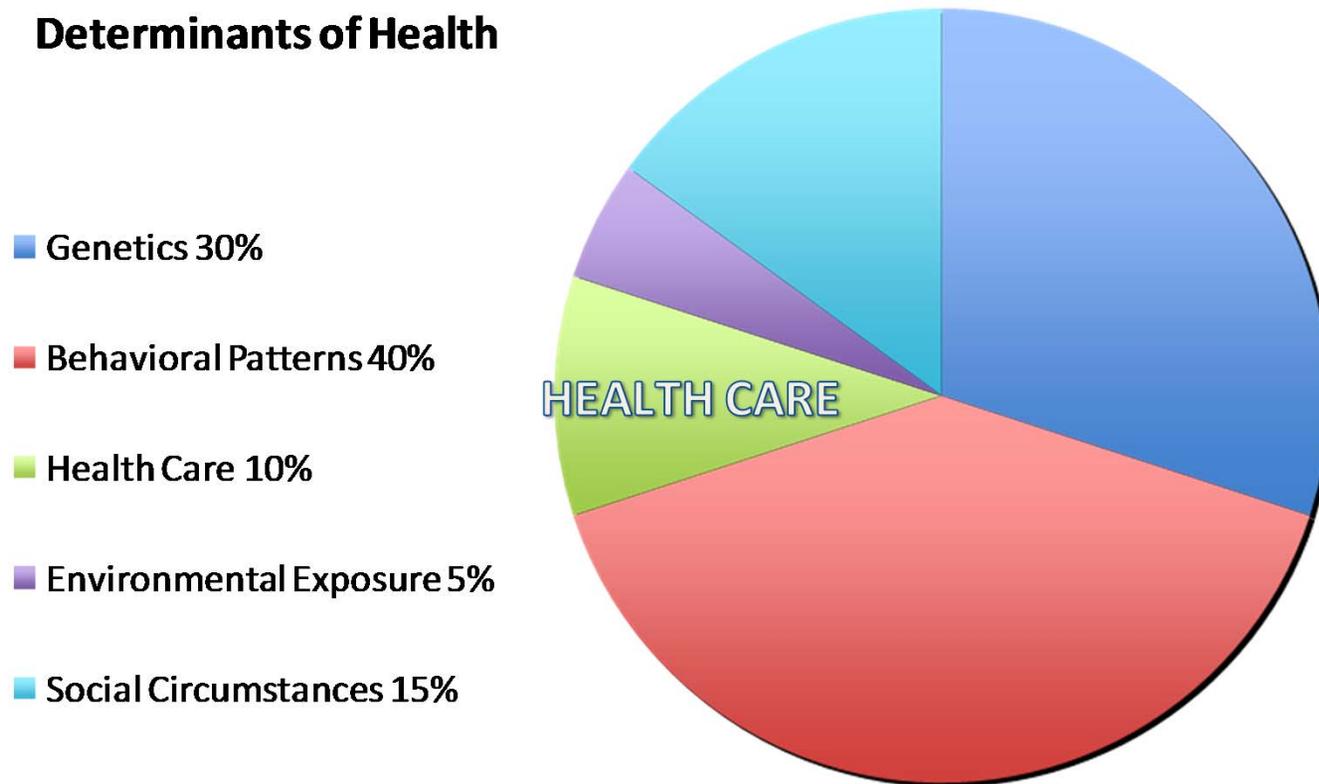
- One Size does not Fit All
 - Deductibles & co-payments decreases use of all types of services
 - People avoid necessary AND unnecessary care
 - But if there is NO cost-sharing, people use more of both necessary AND unnecessary care
- People's incomes matter
 - Cost-sharing hits sicker and lower income people harder
 - Encourages avoidance of all care

Cost-sharing matters: research shows...

- *Smart* cost-sharing
 - Does not discourage important, essential care
 - annual check-ups, immunizations
 - Does not discourage the use of patients' medications
 - Encourages appropriate consideration of pros and cons of potentially unnecessary procedures that do not have proven benefit and can be wasteful to the system

FACTORS INFLUENCING HEALTH STATUS

Determinants of Health



Adapted from Schroeder, SA. We can do better-Improving the health of the American people. NEJM 2007;357:1221-8

SMALL GROUP EXERCISE: PRIORITIES & PREFERENCES



Summaries of what we hear from you will be here:

www.hcr.vermont.gov

THANK YOU FOR COMING!

Health Care Reform Benefits Listening Session
Exercise 1: Hopes and Fears

DEFINITIONS OF CARE: for informational purposes

Act 48 of 2011 states:

The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters.

Please take a few moments to review three different definitions of Medical Necessity.

Definition #1

Source: Institute of Medicine

“...a condition of benefit coverage usually found in insurance contracts, allowing health insurers to review the appropriateness of any intervention a patient receives.” (usually with a list of included and excluded services)

- **Medical purpose:** preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms
- **Scope:** type, frequency, extent, site, duration
- **Evidence:** known to be effective ranging from scientific evidence to professional standards to expert opinion
- **Value:** cost-effective for this condition compared to alternative interventions including no intervention

Definition #2

Sources: Vermont regulation (REG-H-09-03-1) and National Health Law Program (compiled by the Vermont Workers Center)

“Medically necessary care” means health care services, equipment and pharmaceuticals, including for purposes of diagnostic testing, preventive services, treatment of a condition and aftercare, that are appropriate in the opinion of the treating health professional, in terms of type, amount, frequency, level, setting, and duration to the patient's diagnosis or condition. Medically necessary care must be provided in accordance with national standards of medical practice generally accepted at the time the services are rendered.

Medically necessary care must:

- help restore or maintain the individual's health; or
- prevent deterioration or palliate the individual's condition; or
- prevent the reasonably likely onset of a health problem or detect an incipient problem; or
- assist the individual to achieve or maintain maximum functional capacity in performing daily activities.

Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. Children's medical necessity decisions will be governed by the EPSDT coverage rules (42 USC § 1396(r)(5) and 42 USC § 1396d(a))

Definition #3

Source: CIGNA HealthCare Definition of Medical Necessity for Physicians

“Medically Necessary” or “Medical Necessity” shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with the generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’ illness, injury or disease; and
- not primarily for the convenience of the patient or Physician, or other Physician, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease

For these purposes, “generally accepted standards of medical practice” means:

- standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community;
- Physician Specialty Society recommendations;
- the views of Physicians practicing in the relevant clinical area; and
- any other relevant factors.

Preventive care may be Medically Necessary but coverage for Medically Necessary preventive care is governed by terms of the applicable Plan Documents.

Also take a few moments to review the different types of care that will be provided under Act 48.

Preventive care – Health services provided by health care professionals to identify and treat asymptomatic individuals who have risk factors or preclinical disease, but in whom the disease is not clinically apparent, including immunizations and screening, counseling, treatment, and medication determined by scientific evidence to be effective in preventing or detecting a condition.

Wellness Services – Health services, programs, or activities that focus on the promotion or maintenance of good health.

Primary care – Health services provided by health care professionals specifically trained for and skilled in first-contact and continuing care for individuals with signs, symptoms, or health concerns, not limited by problem origin, organ system, or diagnosis, and shall include family planning, prenatal care, and mental health and substance abuse treatment.

Chronic care – Health services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, prevent complications related to chronic conditions, engage in advanced care planning, and promote appropriate access to palliative care. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, and hyperlipidemia.

Acute/episodic care – Emergency services



Health Care Reform Benefits Listening Session Exercise 1: Hopes & Fears

In this exercise we are asking you to consider the health care we all seek during our lifetimes and provide feedback on your and your community's health care needs.

We have provided a sheet labeled "Definitions of Care" for your information. For those who are less familiar with health care terms or types of care, this sheet might assist as background for the discussion.

Groups will gather in circles. Please choose a facilitator and note taker for the group discussion.

1. *Please discuss what your hopes and fears are for a universal health care system. Please go around the circle and allow each person a chance to contribute. Some suggested questions are:*
 - a. ***What health services do you feel are essential to yourself or your community?***
 - b. ***What health services do you think are less important?***
 - c. ***What services are easy to access in your community?***
 - d. ***What services are difficult to access in your community?***

2. *Each person will be provided with two index cards.*

On the first card please write your hopes for our new universal health care system.

On the second card please write any fears you may have regarding the care you will receive under the universal system. What are you worried about? What would alleviate your worries?

Please feel free to provide additional thoughts if you would like.

Thank you for your input!



Health Care Reform Benefits Listening Session Exercise 2: Preferences & Priority Setting

In the first round of Listening Sessions, we asked participants to make choices about how to finance a universal health care system in Vermont.

In this round, we are asking you to tell us which health care services are most important to you and your community.

There are a number of services that are widely agreed upon as “essential.” Under new federal law these services must be covered by your insurance plan and under Green Mountain Care. These services closely match the benefits packages that most insured Vermonters have now. Out-of-pocket expenses will have limits and be designed to encourage the use of services that improve health outcomes. The 10 categories of essential health benefits include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and chronic disease management
- Laboratory services
- Preventive and wellness services
- Pediatric services, including oral and vision care

For this exercise you are the universal payer of health care services in Vermont. You have \$1000 to spend. \$1000 represents current spending. Please note that the numbers we are using are approximations we arrived at to illustrate choices on spending. In reality, current spending in Vermont on health care is \$5.5 billion per year.

Through health care reform we expect to create savings for projected spending that may be used. So let's assume:

Current spending = \$1000

Of your \$1000 you have already spent \$900 to cover the required essential health benefits that are listed above.

You have \$100 left in savings to spend on services not included in the essential benefits. You can add services, eliminate out-of-pocket expenses, or some combination. You can also raise additional funds to cover additional services or shift out-of-pocket expenses.

(Turn over)

The following services are not included in the essential benefits.

Here is what they cost:

- Adult dental costs **\$20**
- Adult vision costs **\$5**
- Long term care costs **\$75**
- Other services cost **\$5**
- You could also eliminate out-of-pocket expenses for **\$140** or reduce it for **\$70**

How would you spend your money? Remember, you have \$100 in savings. If you go over the \$100, are you willing to raise additional funds so you can include more services? Or do you have an idea to generate additional savings?

Health Care Service	Would you include this service? Y or N?	If Yes, fill in the cost from above
Dental		\$
Vision		\$
Long Term Care		\$
Eliminate/Reduce cost-sharing		\$
Other (_____)		\$
	TOTAL:	\$

How would you raise additional funds or save money? Check all that apply.

1. **Charge a “premium”** (defined monthly amount)
2. **Increase cost-sharing** (out-of-pocket expenses when you use services)
3. **Raise taxes** If you know which one, list here: _____
4. **Cut or limit another health service.** Which service?

5. **Cut another public service and move the money to health care.** Which service?

6. **Create additional savings.** How? _____
7. **Create a supplemental insurance market where people could purchase coverage for additional services at an additional cost.** Which services would you move to a supplemental market (you cannot move essential services)?

Additional ideas or comments (feel free to use an index card):
