



Toward Evidence-Based Health Care Reform Volume 3, No. 9

New Mandates and More Studies

We hope the following serious problems aren't ignored as House Health's 80+ page "omnibus" bill rolls toward a House vote:

Sec 2 called "Building Blocks for Reform" funds nearly \$250,000 in new studies. The best way to position Vermont for the future would be to (1) complete the reforms we've already started and (2) do them sustainably and without financing by deficit spending and cost shifting.

- ◆ Catamount Health is only five months old. *What will year #2 cost? How will we deal with the known projected deficits in 2008-2010?* Can we be sure that providers will continue to participate at payment levels of 10% above Medicare?
- ◆ BISHCA, OVHA, VDH and the Blueprint staff must once again set aside current reforms to conduct numerous studies with very short timelines. Act 191 already created 300+ new tasks for agencies; this bill piles on more, taking time away from rigorous implementation. *Let's do a few things well instead of a lot of things poorly.*
- ◆ We still haven't found a way to control hospital costs and hospital rate increases. More studies are proposed, but in the meantime one of the key factors driving costs --- *the Medicaid cost shift, is not being reduced by one dime this session.*
- ◆ **The cost shift goes on, unabated.** Section 20 calls for a *study* of the cost shift. "Been there; done that." Several times already since 2000, in fact. For example, this bill's study would:
 - "define the cost shift" (*already done in the 2006 study by BISHCA*).
 - "develop ways to quantify the contribution of Vermont's Medicaid program to the Medicaid cost shift" (*already done in the 2006 study by BISHCA*)
 - "quantify the effects...on ... health insurance premiums...as well as impact on property taxes (*already done by JFO in Jan-Feb 2008*)
 - "develop ... a five year plan to ensure sustainable financing for Vermont's health care programs, including Medicaid and Catamount Health." (*Already done by the legislature and JFO in July 2004.*) The Health Access Oversight Committee Jan 2007 report on eliminating the Medicaid deficit is also applicable --- the answers are always the same: reduce expenditures or raise more general fund revenues.

It's time to quit stop spending scare resources on more studies; it's time to start looking at the findings from studies taxpayers have already paid for.

It's time to make the tough choices. Either reduce expenditures in hospitals by Medicaid/VHAP/Dynasaur patients or raise payments to hospitals by raising taxes.

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The current draft bill will “cost shift” coverage expansions to employer-employee health insurance via *new mandates*.

Section 4 mandates that employer-employee plans cover the divorced spouses of employees for up to three years following divorce.

- ◆ What if the divorced spouse leaves Vermont? What if the employed spouse leaves the job? What if the divorced spouse doesn't pay the premium? None of this is addressed in the bill.
- ◆ Divorced spouses *are already eligible for Catamount Health* without a waiting period! So why is the committee trying to cost shift these folks into employer-employee sponsored coverage?

Section 5 requires plans to cover adult children up to age 24.

- ◆ These young adults *are already eligible for Catamount Health* as soon as they no longer are eligible for their parents' coverage. Why cost shift them to employer-employee plans?

A section called “Fair Standards for Provider Contracts” allows providers to “cherry pick” which plans and networks they'll participate in.

The provision would *prohibit insurers (including self-insured plans)* from requiring a contracted provider to participate in all products and plans. *This allows providers to “cherry pick” plans* they'll participate in. The confusion for consumers (whose employers might be offering them multiple plans to choose from), and the ability of providers to choose only the most lucrative deals, seriously hinders reform efforts.

- ◆ What happens when a consumer wants to change plans but keep their doctor?
- ◆ What if doctors agree to BlueCross Freedom Plans, but not BC Catamount Health? What if doctors agree to sign with MVP only for plans with minimal utilization management and the highest reimbursement levels?
- ◆ What about the other pilot projects the committee envisions, like HealthyLiving, Medical Home and the Accountable Care Organizations: *if carriers are mandated to offer plans, why aren't providers mandated to participate in those plans?*

By cherry picking plans, providers can dictate which plans will be available. *Do we want to let the “suppliers” dictate the terms of our health plans?*

LET'S NOT “REFORM” FOR THE SAKE OF REFORM.

LET'S REFORM IN A WAY THAT MAKES SENSE AND THAT WE KNOW

WE CAN SUSTAIN.

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