



Toward Evidence-Based Health Care Reform

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Catamount Health Plan: The Shape of What's to Come

Welcome to "Toward Evidence-Based Health Care Reform," a periodic e-memo providing facts, figures, examples and analysis of current issues in health care reform in Vermont. The memo is written by Jeanne Keller, Keller & Fuller, Inc., and sponsored by BRS, Inc., a member organization providing a range of services and support to Vermont's small businesses. For more about BRS, please visit our website: www.brsvt.com

To review past issues of Toward Evidence-Based Health Care Reform, www.vtreform.com.

To read and download the comprehensive health care reform proposal supported by BRS and several other Vermont business associations, www.vtiha.org.

This week BISHCA issued draft regulations for implementation of Catamount Health Plan, the subsidized insurance plan for the uninsured that will be offered by private carriers starting in October 2007. To expedite implementation, BISHCA is following an Emergency Rule Making timetable and the time for public input is very short.

Why should the public care about the final shape of these rules? Two reasons tower above all others. First, Catamount is an expensive and major new state program: between 2007 and 2010, if projections hold true, Catamount Health will cost the state over \$110 million dollars to provide insurance to an estimated 16,000 previously uninsured persons. Second, if strong "walls" are not built around this plan to limit it to the uninsured, to limit cost growth, to limit enrollment to the budgeted amount, and to limit fiscal risk to our carriers, Catamount could devour our state budget and damage our current health care financing system. A large part of the challenge to building such walls is that the legislature was extremely explicit in their reform bill – now called **Act 191**. The law spells out virtually all details of Catamount Health, leaving little discretion to the Executive Branch and the carriers. Act 191 dictates, for example, the exact dollar amount of deductibles, co-payments and total out-of-pocket expenses to the insured. The law specifies that the carrier must contract with

"any willing provider," and be a preferred provider plan. The law also specifies premium contributions by income bracket, meaning any gap between the premium cap and plan cost must be paid by the taxpayers. There's little room for flexibility and negotiation with carriers for an affordable, adequate plan.

This means that much of what concerns us in the regulations is a problem with the law that underlies the regulations. BISHCA, for the most part, must carry out the micro-details found in Act 191. Where there is discretion, however, it's important to examine how that discretion is used, and to press BISHCA always to use the discretion toward cost containment, since little else in the legislation moves in that direction.

The entire proposed rule (13 pp) can be downloaded from the BISHCA website:

www.bishca.state.vt.us. (Scroll down the left side to "Catamount Health Proposed Rules.")

We have completed a preliminary analysis of the rule. To review our analysis, click [here](#). If you'd like to participate in commenting on the proposed rules, to add your voice in support of cost containment, here's what you can do:

- Review our comments and include anything you want in your own letter to BISHCA. For a template for your own letter to BISHCA, click [here](#). OR
- [Email to us](#) your authorization to sign your name to our comments. AND

Encourage your colleagues to join you in this effort. Contact business associations to which you belong and encourage them to comment. Feel free to forward this to anyone.