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Achieving Universal Coverage through Comprehensive Health Reform: The Vermont Experience

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Summary

- Universal health care legislation, passed in Vermont in 2006, has met its goal of significantly increasing the number of insured Vermonters and aims to further impact care through improving quality and containing costs.
- The percentage of uninsured Vermonters has decreased significantly since 2006, and enrollment in both public insurance programs and private insurance has increased.
- Vermonters have learned that health care reform will be an ongoing process, requiring a great deal of stakeholder collaboration.
- Vermont's public insurance programs are not likely to be sustainable in the long term without both federal assistance and system-level improvements.

Vermont's passage and implementation of comprehensive health reform is often overshadowed by the efforts of Massachusetts, but preliminary evaluation findings on health reform in Vermont offer a number of lessons to other states. This report presents the interim results of a two-year comprehensive evaluation examining the impact of health care reform in Vermont as initiated by the 2006 Health Care Affordability Acts. The evaluation addresses three key dimensions of Vermont's comprehensive health reform, including (1) health coverage affordability, (2) health services access (especially access to primary health care), and (3) reform sustainability. This first-year report includes findings from key informant interviews, analyses of affordability, initial findings from enrollment data, baseline data on fringe benefits, and preliminary analyses of sustainability.

HISTORY OF REFORM

The State of Vermont has a long history with health care reform. Recent efforts have included Medicaid expansions beyond the traditional income limits, including expansions in 1989 to cover uninsured children and an expansion in 1995 to cover low-income, uninsured adults. Despite the success of these programs, a survey conducted in 2005 found that approximately 10% of Vermont's population remained uninsured and per capita health care costs were rising faster than the US rate.ⁱ Faced with this information, Vermont's policymakers agreed that the state could not provide better access to health insurance without extensive health care reform.

In May 2006, the legislature passed and the Governor signed Acts 190 and 191, the Health Care Affordability Acts (HCAA) for Vermonters. Implementation of the HCAA began in early 2007. Lawmakers have continued to modify the Act since its initial passage in order to address implementation issues as they have arisen.

In considering reform, legislators had the following overarching goals:

1. To achieve universal access to affordable health insurance for all Vermonters
2. To improve quality of care and contain costs through health care system reform
3. To promote healthy behavior and disease prevention across the lifespan

These goals were interrelated: access to health insurance would increase the use of preventative services; lower health care costs would make insurance premiums more affordable; and promotion of healthy behavior and preventive services would help keep health care costs in check. Each component would play an essential role in ensuring successful reform.

The 2006 HCAA was designed with these reform goals in mind. To achieve the first goal, the HCAA created two public health insurance programs intended to provide access to affordable insurance to the state's uninsured:

- The **Catamount Health Insurance Program** (Catamount Health) is a subsidized health insurance program intended to provide affordable health insurance coverage to those who are not covered through their employer but who exceed the income limitations for current state and federal Medicaid programs. Catamount Health is available to all Vermonters and can be purchased at full cost or at a reduced cost with state premium assistance according to a sliding income-based scale.
- Under the **Employer-Sponsored Health Insurance (ESI) Premium Assistance Program**, the State provides financial assistance to certain uninsured employees to help them take advantage of insurance offered by their employer. The ESI Premium Assistance Program is designed to lower the state costs of expanding health insurance coverage by subsidizing enrollment of individuals into their employer's health plan when such enrollment is cheaper than VHAP or Catamount Health.

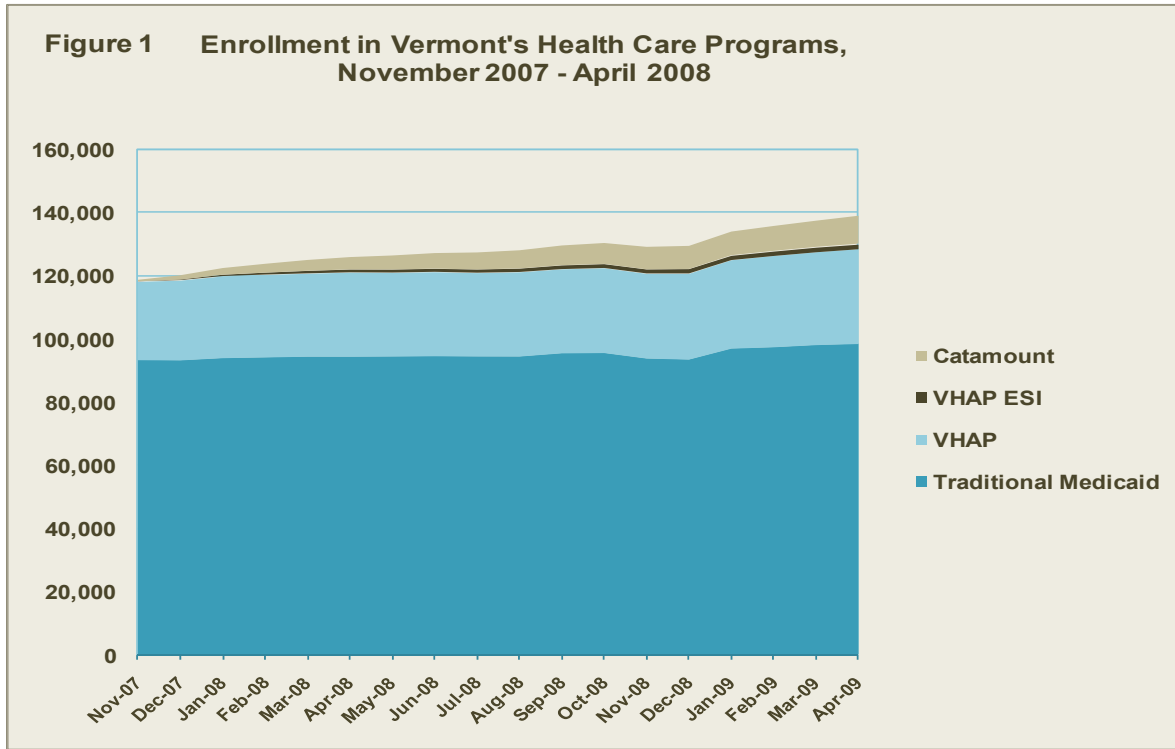
Blueprint for Health (which is currently being implemented) is an initiative that was created to address the second and third goals of the HCAA, focusing on the prevention and management of chronic conditions to improve quality of care and reduce health care costs.ⁱⁱ The program is intended to help primary care providers operate their practices as advanced medical homes that offer coordinated care supported by local services, health information technology tools, and provider reimbursement mechanisms.ⁱⁱⁱ The 2006 HCAA also required the Office of Vermont Health Access (OVHA) to develop a chronic care management program with similar standards for new Catamount enrollees and Vermonters enrolled in other state health programs.

EARLY ENROLLMENT RESULTS

The percentage of uninsured Vermonters has decreased

Between 2005 and 2008, the percentage of Vermont residents aged 0 to 64 with some type of insurance coverage increased by 2.4%, raising the percentage of insured residents in this age group from 88.8% to 91.2%. During this time

period, insurance coverage in Vermont increased more rapidly than in other New England states, with most of the increase in Vermont's coverage coming through increases in public coverage.^{1,2}



Enrollment in both public insurance programs and private insurance has increased in Vermont

Enrollment in the new Catamount Health program increased sharply and steadily during the initial months. By April 2009, a total of 8,758 people were enrolled in Catamount Health. Most Catamount enrollees receive premium assistance. Only 13.9% of enrollees have family incomes above 300% FPL and do not receive premium assistance.

Outreach campaigns have been effective

Although Catamount Health has played a role in reducing the percentage of uninsured Vermonters, it has not been the only factor. An aggressive outreach campaign has spread knowledge about both new and existing programs, and it has facilitated enrollment in these programs. Analyses show that participation in public programs rose substantially among those who had been eligible for public coverage before the recent expansions. Insurance coverage rates increased 3.1% among those who had always been eligible for public insurance and 3.5% among those who were newly eligible for public coverage. In comparison, coverage rates increased more moderately (1.1%) among those who were never eligible for public coverage.

These data suggest that increased outreach to populations already eligible for public insurance in Vermont may have led to an increase in enrollment into existing Medicaid programs. Outreach to childless adults, who were eligible for the

¹ In order to examine the trends in New England without the impact of health reform, both Vermont and Massachusetts were left out of the New England analyses. Vermont's increase of 2.4% was substantially greater than in the remainder of New England, which increased less than 1%.

² Excluding Vermonters 65 and older from the analysis permits a focus on those who are most likely to be uninsured and therefore the target of health reform efforts, since Vermonters 65 and older are all eligible for Medicare coverage. However, systematically excluding an overwhelmingly insured cohort from also decreases the percentage of Vermonters with any insurance and increases the percentage of uninsured in any data analyses.

Vermont Health Access Program (VHAP) but may not have known about the program (or may have thought they were ineligible) appears to have been particularly effective, as enrollment in traditional Medicaid increased by 5.5%, while enrollment in VHAP increased by 21.0%.

LESSONS LEARNED DURING IMPLEMENTATION

Implementation of health reform is an ongoing process

Key informants consistently described the implementation of health reforms in Vermont as a dynamic process, with ongoing changes and modifications to programs. Implementation has been a complex undertaking as evidenced by the four reform bills enacted after the initial HCAA to address shortcomings and/or omissions from the original bill. Continuing to find viable solutions to various issues around implementation is an ongoing process and can be informed by preliminary results and the ability to address challenges as they arise.

Although modifications will be needed to continue the programs, stakeholders remain optimistic about the future of health reform in Vermont. Key informants expressed primarily positive reactions to the ongoing legislative work to refine the HCAA. With the anticipated Vermont State budget shortfalls and the planned oversight built into the HCAA, it is expected that there will be additional changes to the reform efforts in coming years.

Stakeholder collaboration is necessary

Another key lesson for state health care reform efforts is the importance of collaboration: Vermont's story is a lesson in the importance of working collaboratively to achieve large scale health reform. Stakeholders (government, providers, insurers, business and consumers) seemed to agree that enacting state health reform was more important than any particular philosophy regarding ideal health reform. Collaboration continues to be a hallmark of the implementation process.

Federal assistance is needed for sustainability

The program, as currently funded, does not appear to be fiscally sustainable. Vermont is currently using state general fund dollars to offset the unrealized revenue that had been anticipated from federal matching in the Global Commitment Waiver for those individuals between 200% and 300% of the federal poverty level. However, it is widely acknowledged that this level of state funding will only be sustainable in the short term. Unless program expenditure patterns change, new sources of revenues are found, or structural changes in the plans occur, the fund balance will be depleted over time. Vermont is counting on renegotiation in the next waiver renewal process in order to continue offering subsidies for individuals and families at this income level.

Making the eligibility and enrollment process easy is critical

Eligibility and enrollment processes for the various programs have required ongoing attention and readjustment. Some of the barriers to enrollment cited by key informants include: the affordability of the plan (particularly for those individuals who do not qualify for premium assistance), the 12-month waiting period for coverage, and the difficulty of the eligibility determination and enrollment processes. Lawmakers have made ongoing modifications to the programs to address these barriers.

Health system-level improvements are needed

A final lesson from Vermont's efforts at this early stage is the importance of addressing the underlying inefficiencies and problems in the health care system in order to improve health care outcomes and slow the rise of ever-increasing health care costs. The Blueprint for Health has tremendous potential to transform Vermont's health care system from a reactive system to a preventive, proactive system. While these changes will likely occur slowly and require sustained effort and commitment on behalf of decision makers, providers, and the general public, they provide a roadmap for driving overall healthcare system reform. The Blueprint reforms increase the chance that Vermont will end up with a

more cost-effective and high-quality health care system, regardless of future health insurance reforms. Reductions in health spending as a result of the implementation of Blueprint (not a part of this evaluation) may improve sustainability over time.

CONCLUSION

The first year of evaluation of Vermont's 2006 health reform has focused on process evaluation in order to glean insight into the operation of Catamount Health and into the experiences of those working with Catamount and other aspects of the reforms. The percentage of Vermonters without health insurance has decreased significantly since reform began, and insurance coverage in Vermont has increased more rapidly than in other New England states. Most of the increase in Vermont's coverage is a result of increased public coverage—enrollment in Catamount Health has increased sharply and steadily during the program's initial months. Most key informants were generally satisfied with enrollment levels to date, but still perceive barriers to enrollment. Outreach campaigns have been implemented to combat some of these barriers, and are perceived to be effective in educating the public about reform programs. However, health reform does not appear to be fiscally sustainable in the long-term. Despite this, key stakeholders are optimistic about the future of health reform programs. Implementation of these programs has been viewed as an ongoing experiment, allowing for mid-course corrections to program procedures and enrollment projections.

Next steps

In the future, analysis will continue to focus on potential change to the structure of the health reform programs themselves and on potential changes to the costs and financing of these programs. Most informants believe that these programs will be around indefinitely but will be adjusted on an ongoing basis as challenges present themselves. In the second year of evaluation, we will expand our analysis with an additional year of survey data, health utilization and cost data on Catamount covered populations, and with improved analytical models. It is also important to examine an area not yet explored—the impact of the reforms on access to care. These analyses will provide a more accurate picture of program use and sustainability and in turn permit a more informed policy discussion of mechanisms to address sustainability.

The full report, **Achieving Universal Health Coverage through Comprehensive Health Reform: The Vermont Experience (Year 1 Interim Report)**, can be found at http://www.shadac.org/files/shadac/publications/VT_Interim_Report.pdf.

NOTES

ⁱ2005 Vermont Household Health Insurance Survey: Final, August 2006 Report; available at: http://www.bishca.state.vt.us/HcaDiv/Data_Reports/healthinsurmarket/2005_VHHIS_Final_080706.pdf and National Health Expenditure Data, Health Expenditures by State, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, released February 2007; available at http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccountsResidence.asp#TopOfPage.

ⁱⁱ Conis, Elena. "Vermont's Blueprint Chronic Care Initiative". Health Policy Monitor, November 2008. Available at: <http://www.hpm.org/survey/us/a12/1>.

ⁱⁱⁱ Vermont Blueprint for Health, 2007 Annual Report, produced by Vermont Department of Health, Agency of Administration, January, 2008. Available at: <http://healthvermont.gov/prevent/blueprint/documents/BlueprintAnnualReport0208.pdf>.

ABOUT THE SHARE INITIATIVE

SHARE is a national program of the Robert Wood Johnson Foundation and is located at the University of Minnesota's State Health Access Data Assistance Center (SHADAC).

The SHARE project has the following key goals:

1. Coordinate evaluations of state reform efforts in a way that establishes a body of evidence to inform state and national policy makers on the mechanisms required for successful health reform.
2. Identify and address gaps in research on state health reform activities from a state and national policy perspective.
3. Disseminate findings in a manner that is meaningful and user-friendly for state and national policy makers, state agencies, and researchers alike.

To accomplish these goals, SHARE has funded 16 projects covering 29 states.

CONTACTING SHARE

The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that aims to provide evidence to state policy makers on specific mechanisms that contribute to successful state health reform efforts. The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. Information is available at www.statereformevaluation.org.

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