S.129

An act relating to containing health care costs by decreasing variability in health care spending and utilization

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. STUDY OF HEALTH CARE UTILIZATION

(a)(1) The commissioner of banking, insurance, securities, and health care administration shall analyze variations in the use of health care provided both by hospitals and by physicians treating Vermont residents as measured across the appropriate geographic unit or units. The commissioner shall contract with the Vermont program for quality in health care (VPQHC) pursuant to 18 V.S.A. § 9416 and may contract or consult with other qualified professionals or entities, including the Maine Health Information Center, the Dartmouth Institute, and the Jeffords Institute for Quality and Operational Effectiveness at Fletcher Allen Health Care, as needed to assist in the analysis and recommendations.

(2) The purpose of the analysis is to identify treatments for which the utilization rate varies significantly among hospitals or among regions within Vermont, where the utilization rates are increasing faster in one hospital or region than another, to determine the causes of and reasons for the variations and increases in utilization, and to recommend solutions to contain health care costs by appropriately reducing the utilization variability, including by

promoting the use of equally effective, lower cost treatment alternatives. The commissioner may examine the utilization rates of comparable, out-of-state hospitals or entities and regions if necessary to complete this analysis.

(3) The secretary of human services shall collaborate with the commissioner of banking, insurance, securities, and health care administration in the analysis required by this section. To the extent that the agency has data to contribute to the analysis that may not be shared directly, the agency shall provide the analysis to the commissioner of banking, insurance, securities, and health care administration.

(4) The commissioner and the secretary may begin the analysis with the following lists of services:

(A) whose utilization is governed largely by patient preference, including:

(i) cataract surgery;

(ii) hip replacement;

(iii) knee replacement;

(iv) shoulder replacement;

(v) back surgery;

(vi) elective angioplasty which does not follow an acute myocardial infarction;

(vii) coronary artery bypass graft surgery (CABG);

(viii) implantable defibrillators;

(ix) carotid endarterectomy; and

(x) lower extremity bypass procedures.

(B) whose utilization is governed largely by the available supply of the service, including:

(i) total physician visits, including to specialists and primary care physicians;

(ii) medical admissions to hospitals, including number of inpatient days and outpatient visits, including emergency room visits;

(iii) ambulatory-sensitive condition rates;

(iv) advanced imaging;

(v) diagnostic tests; and

(vi) minor procedures.

(b) In fiscal year 2010, the commissioner of banking, insurance, securities, and health care administration may redistribute up to $150,000.00 of the amount collected under subsection 9416(c) of Title 18 in order to ensure that the analyses and report required by this section are completed.

(c) No later than December 15, 2009, the secretary of human services and the commissioner of banking, insurance, securities, and health care administration shall provide a report to the house committee on health care and the senate committee on health and welfare containing a summary of their

analysis of health care utilization, including explanations for variations or increases in spending, and recommendations for containing health care costs by reducing the variability in utilization, including promoting the use of equally effective lower cost treatment alternatives, prevention, or other methods of reducing utilization.

Sec. 2. UTILIZATION REVIEW AND REMEDIATION PLAN

Using the analysis required in Sec. 1 of this act as the primary source of analysis, the commissioner of banking, insurance, securities, and health care administration shall consult with the Vermont Association of Hospitals and Health Systems, Inc., the Vermont Medical Society, insurers, and others to recommend:

(1) A process to:

(A) identify inappropriate utilization of treatments in a hospital for which there is a method for reducing utilization, including by ordering an equally effective lower cost alternative treatment;

(B) prioritize utilization variations by considering the impact a reduction in inappropriate variations could have on cost or quality and the potential to develop strategies to reduce inappropriate variations;

(C) determine the causes of inappropriate utilization identified pursuant to the process developed under this subdivision in a particular hospital;

(D) provide information about inappropriate utilization of particular treatments and the causes for the inappropriate utilization directly to the hospital in a publicly available format; and

(E) monitor the hospital's progress toward curbing inappropriate utilization of the identified treatments.

(2) Modifications, if any, to existing regulatory processes, including the certificate of need process, or the annual hospital budget process.

(3) Solutions to reduce inappropriate variation, including initiatives to improve public health and change reimbursement methodologies.

(4) Incentives for hospitals and health care professionals to decrease inappropriate utilization.

Sec. 3. HEALTH PLAN ADMINISTRATIVE COST REPORT

(a) No later than December 15, 2009, the commissioner of banking, insurance, securities, and health care administration, in collaboration with the secretary of human services and the commissioner of human resources, shall provide a health plan administrative cost report to the house committee on health care and the senate committee on health and welfare.

(b) The report shall:

(1) identify a common methodology based on the current rules for insurer reports to the department of banking, insurance, securities, and health care administration for calculating costs of: administering a health plan in

order to provide useful comparisons between the administrative costs of private insurers; entities administering self-insured health plans, including the state employees' and retirees' health benefit plans; and offices or departments in the agency of human services; and

(2) a comparison of administrative costs across the entities in Vermont providing health benefit plans.

Sec. 4. SHARED DECISION-MAKING DEMONSTRATION PROJECT

(a) No later than January 15, 2010, the secretary of administration or designee shall present a plan to the house committee on health care and the senate committee on health and welfare for a shared decision-making demonstration project to be integrated with the Blueprint for Health. The purpose of shared decision-making shall be to improve communication between patients and health care professionals about equally effective treatment options where the determining factor in choosing a treatment is the patient's preference. The secretary shall consider existing resources and systems in Vermont as well as other shared decision-making models.

(b) "Shared decision-making" means a process in which the health care professional and patient or patient's representative discuss the patient's health condition or disease, the treatment options available for that condition or disease, the benefits and harms of each treatment option, information on the limits of scientific knowledge on patient outcomes from the treatment options,

and the patient's values and preferences for treatment with the use of a patient decision aid.