Overview of Vermont’s 2011-2012 Health Care Reform Initiatives

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Vermont Health Benefit Exchange

- Affordable Care Act (ACA) requires states to establish an Exchange by January 1, 2014 or the federal government will operate one on the state’s behalf
- Vermont’s Exchange is a division of the Department of Vermont Health Access
- Purpose of the Exchange is to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified employers
- “Qualified employers”:
  - 2014 and 2015: Employers with 50 or fewer employees
  - 2016: Employers with 100 or fewer employees
  - 2017: Large employers can come in, too
- Enrollment begins October 1, 2013 for coverage beginning January 1, 2014
- Exchange must be self-sustaining by 2015; financing plan due January 15, 2013
- All individual and small group plans must be sold through Exchange
- Individual and small group markets merged
- Exchange plans must provide the essential health benefits package
- Exchange must offer:
  - Bronze (60% actuarial value(AV)), silver (70% AV), gold (80% AV), and platinum (90% AV) plans
  - At least two multistate plans established by the federal government
  - Plans offered by nonprofit insurers created under the CO-OP program
- Purchasers in individual market are eligible for federal premium tax credits up to 400% FPL and cost-sharing subsidies up to 250% FPL
- Navigator program will provide information and facilitate enrollment in Exchange
- Penalties for employers with 50 or more FTEs if they:
  - do not offer health insurance and at least one employees gets subsidized coverage in the Exchange
  - offer health insurance but an employee gets subsidized coverage in the Exchange because the employer’s plan is unaffordable to the employee (> 9.5% of household income) or has an actuarial value less than 60%
- Plans in effect on March 23, 2010 are grandfathered unless/until lose grandfathered status by, e.g., significantly increasing co-pays, coinsurance, or deductibles, or significantly decreasing employer contribution

Green Mountain Care (GMC)

- Publicly financed universal health care (“single-payer”) program
- To be implemented 90 days after the ***last*** of the following to occur:
  - Vermont receives a waiver from the federal Exchange requirement (currently unavailable until at least January 1, 2017)
  - General Assembly enacts a law to finance GMC
  - GMC Board approves the initial GMC benefit package

    - General Assembly passes appropriations for the initial benefit package
    - GMC Board makes specific determinations about GMC's impacts
- All Vermont residents will be eligible for GMC
- No one will be required to terminate other health coverage; may keep supplemental coverage, too
- Does not reduce Medicare benefits - GMC "wraps around" Medicare
- GMC must include at least the same covered benefits as Catamount Health
- Financing plan due January 15, 2013

Green Mountain Care (GMC) Board

- Five-member board, created in Act 48 (2011)
- Purpose of GMC Board is to promote the general good of the state by:
    - Improving health
    - Reducing per-capita rate of growth in health care spending without compromising access or quality
    - Enhancing patient and health care provider experiences
    - Recruiting and retaining high-quality health care professionals
    - Achieving administrative simplification in health care financing and delivery
- GMC Board's duties:
    - Oversee and evaluate health care payment and delivery system reform to contain costs and maintain quality; includes payment reform pilots
    - Review and approve the Statewide Health Information Technology Plan
    - Review and approve Health Care Workforce Development Strategic Plan
    - Review Health Resource Allocation Plan
    - Set rates for health care professionals
    - Health insurance rate review (in conjunction with the Department of Financial Regulation)
    - Hospital budgets
    - Certificates of need
    - Review and approve benefit package(s) for qualified health benefit plans to be offered in the Vermont Health Benefit Exchange
    - Evaluate systemwide performance and quality
    - Develop unified health care budget
    - Review data regarding mental health and substance abuse treatment
    - Define Green Mountain Care (GMC) benefit package
    - Recommend annually a rolling three-year budget for GMC

Waivers

- AHS seeking federal waiver to serve "dual eligible" population (eligible for both Medicaid and Medicare)
- AHS seeking new/renewed waiver(s) for Medicaid, Choices for Care, SCHIP