Vermont Association of Hospitals and Health Systems

Testimony: S.120 & S.132 Health Care Reform and Affordability Proposals

Recommendations

Affordability and S.120: VAHHS proposes the following

- Focus on health care coverage affordability to provide real relief to Vermonters and monitor delivery system reform efforts through AHS's implementation improvement plan
- Use the Health Care Reform Oversight Committee to create momentum with key legislators
- Work should build off previous affordability proposals, and implement opportunities under the American Rescue Plan Act to provide real relief to Vermonters
    - Streamlining care coordination
    - Cost shift and affordability
    - HSA reform to allow for coverage of primary care visits
    - Subsidies available for households with income of $76,560 for a single individual or $157,200 for a family of four
    - Extending Medicaid postpartum for 12 months
- Use listening sessions to educate Vermonters about immediate affordability options

Health Care Reform and S.132: VAHHS does not support S.132 because it creates significant instability in an already fragile health care system by moving away from evidence-based provider-led decision making to redistributing health care funding through a small panel without clinical expertise.

Protecting 340B Program for Hospitals and FQHCs: Adopt legislation from Utah which would prohibit pharmacy benefit managers (PBMs) from creating additional requirements or restrictions on the federal 340B drug pricing program.

S.120 and Health Care Coverage Affordability

VAHHS supports affordable health care coverage that promotes access to quality care. Over the past few years, Vermont's hospitals have seen an increase in uncompensated care, which is a good indication that the current health care coverage is unaffordable creating negative health outcomes for Vermonters and contributing to the fragility of Vermont's rural hospital system.

Vermont needs actionable proposals that build upon previous health care affordability work. Instead, S.120 provides a broad charge to a new committee of legislators.

Use key legislators to build off previous health care reform experience

Instead of utilizing the current Health Reform Oversight Committee (HROC), which includes committee members relevant to health care, finance, and spending, S.120 proposes an entirely new committee to be disbanded after the report. This new committee will not have the expertise of HROC and will create another layer of work as the recommendations make their way through each legislative committee as opposed to being endorsed by HROC. VAHHS recommends that this report goes through HROC to build off previous experience and create momentum from key legislators early on.

Committee charge should be focused on affordability, build off previous affordability work, and implement opportunities under the American Rescue Plan Act to provide real relief to Vermonters

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S.120 gives the temporary committee the broad charge of both making health care coverage more affordable for Vermonters and to evaluate the efficacy of the All Payer Model. These are two different types of reform. The All Payer Model is provider delivery system reform, and is designed to reduce the costs of the health care system over the long term by employing preventive services today to create better health outcomes for tomorrow. While it is making measurable differences for the child in mental health crisis who can now go to Psychiatric Urgent Care for Kids instead of the emergency department and the food insecure diabetic who benefits from the coordinated services of her community care team, it is different than providing immediate relief through premiums and deductibles.

Additionally, the All Payer Model and ACO are overseen and evaluated by both the federal government and the Green Mountain Care Board. In response to the federal government's latest evaluation, AHS adopted an implementation improvement plan. A separate and additional evaluation would be redundant and take staff resources away from the ACO, the Green Mountain Care Board, and DVHA. Instead, the legislature should require regular reporting on the progress of this plan.

One area of health care delivery system reform that could provide short-term health care coverage affordability is the potential overlap between provider-based care coordination and commercial insurance care coordination. S.120 could examine whether this overlap exists and make recommendations on how to streamline without losing efficacy.

To really address premiums and cost-sharing, the committee should focus on health care coverage affordability, and should build off previous work such as: Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Health Care System, to the 2015 Universal Primary Care Study, the 2016 Report on Universal Primary Care and the Cost Estimates for Universal Primary Care as well as the JFO Review of Agency of Administration's Study of Primary Care and JFO Independent Review of the Agency of Administration's Final Estimate of the Costs of Providing Primary Care to All Vermont Residents. Section 2(c)(5) of S.120 specifically asks the committee to look at Dr. Dynasaur expansion through age 25, even though a 2017 report on the effects of Dr. Dynasaur expansion found that such expansion would increase premiums by $1,000 for individuals on employer-sponsored insurance.

Even with utilizing a consultant and JFO, reexamining previous affordability proposals takes real staff time away from DVHA and the Green Mountain Care Board. This is time and resources that could be better spent addressing questions from previous reports and maximizing the new opportunities afforded by the American Rescue Plan Act.

Instead of starting with a blank slate, the HROC could address issues from previous reports, such as:

- Medicaid cost shift: one issue with single payer was that Medicaid funding did not keep up as anticipated
- Health Savings Accounts (HSAs): the Universal Primary Care studies showed that HSAs should be reformed at the federal level to support Vermont initiatives, such as coverage of two primary care visits

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The changes in the American Rescue Plan Act are going to have a huge impact on Vermonters. For real and immediate affordability, the HROC should examine the affordability provisions in the American Rescue Plan Act, which include:

- Expansion and increase in premium subsidies— For 2021 and 2022 individuals on Vermont Health Connect will pay no more than 8.5% of their household income—this means subsidies will go to households with income of $76,560 for a single individual or $157,200 for a family of four
- COBRA subsidies at 100 percent for six months from April 1- Sept. 30, 2021
- State option for extension of Medicaid and CHIP coverage postpartum for 12 months

These provisions raise a series of decision points around affordability that HROC and DVHA could work through to make a real and immediate impact for health care affordability next session, such as:

- Vermont pays $5 million in premium subsidies in addition to the federal subsidy. What is the impact of the new ARPA subsidies on Vermont's premium assistance program and should that program continue or be reallocated?
- Can we fix the "family glitch" where employer-sponsored insurance that is considered affordable for a single person but is unaffordable for a family precludes individuals from receiving subsidies?
- Is subsidized insurance through Vermont Health Connect more affordable for Vermonters than employer-sponsored insurance, and should employers consider dropping coverage?

Asking questions about whether more Vermonters should receive subsidies through Vermont Health Connect is important for future health care coverage expansion because the federal government considers the total amount of subsidies received when funding programs through Section 1332 State Innovation Waivers.

Additionally, the proposed listening sessions in S.120 are a missed opportunity to engage and educate Vermonters on the new ARPA subsidies and the options available to Vermonters to maximize affordability. DVHA will have to do separate outreach instead of working in concert with the legislature.

To provide Vermonters with immediate affordability, the legislature needs to work on previous work and analyze and create proposals using the new ARPA provisions and educate Vermonters on the changes that are happening right now to their premiums and out of pocket costs.

S.132 and Health Care Reform

VAHHS cannot support this bill. Changing health care delivery system reform from provider-led and evidence-based to a state-based regulatory exercise by a small panel without clinical expertise will likely damage Vermont's fragile health care system. We saw the unintended consequences of shifting health care dollars when the legislature cut DSH funding to hospitals in FY 2018 and redistributed it to the Designated Agencies to reduce wait times in emergency departments for individuals in mental health crisis. Today, ED wait times for individuals in mental health crisis are higher than ever and the DSH cut

contributed to Springfield Hospital's bankruptcy. S.132 creates this same dynamic on a grand scale, and VAHHS cannot support such efforts.

Below are the section-by-section responses from VAHHS:

Section 1: VAHHS supports the Director of Health Care Reform coordinating and leading all initiatives relating to health care reform, including innovations in health care system payment and delivery. This will allow the Green Mountain Care Board to focus its efforts on regulation.

Section 2: VAHHS supports AHS having oversight of AHS having oversight over the APM targets after the renewal of the APM.

Section 3: VAHHS does not support further oversight of the ACO because the current oversight and the AHS Implementation Improvement Plan provides sufficient oversight.

Section 4: VAHHS does not support moving away from evidence- and provider-led delivery system reform and towards redistribution of health care dollars by a small panel without clinical expertise.

Section 5: VAHHS does not support this section because the ACO already performs this function.

Section 6: VAHHS does not support government audits of private organizations.

Section 7: VAHHS does not support the GMCB determining the methodology for value-based payments nor approving every health care contract between every provider and commercial insurer. This creates instability and unpredictability into Vermont's health care system.

Section 8: This provision requires the GMCB to review and approve every health care contract between every provider and commercial insurer. This is administratively burdensome and invites instability and unpredictability into Vermont's health care system.

Section 9: VAHHS is neutral on fair contract standards.

Section 10: This provision requires the GMCB to study how it would review and approve every health care contract between every provider and commercial insurer. The order of magnitude for this work is thousands of contracts and invites instability and unpredictability into Vermont's health care system.

Section 16: VAHHS supports a GMCB report on increase in health insurers' admin expenses over most recent 5-year period and would add a reporting requirement for care coordination to determine if there is overlap between health care providers and insurers. Proposed language includes:

> 8 V.S.A. § 4062
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> (b)(1) In conjunction with a rate filing required by subsection (a) of this section, an insurer shall file a plain language summary of the proposed rate. All summaries shall include a brief justification of any rate increase requested, the information that the Secretary of the U.S. Department of Health and Human Services (HHS) requires for rate increases over 10 percent, <u>the percentage of total premium revenue expended on care coordination and management provided to enrollees by the insurer</u>, and any other information required by the Board. The plain language summary shall be in the format required by the Secretary of HHS pursuant to the

> Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and shall include notification of the public comment period established in subsection (c) of this section. In addition, the insurer shall post the summaries on its website.

Section 17: VAHHS is neutral on the Director of Health Care Reform reporting on how specialty care will be incorporated in APM.

Section 18: VAHHS is neutral on the ACO reporting initiatives connecting PCPs with social services programs, including specific individuals or position titles responsible for carrying out these coordination efforts

Section 19: VAHHS supports coverage of two primary care visits, but urges the legislature to examine how to reform federal regulations around Health Savings Accounts to allow for this coverage without jeopardizing the tax benefits of a Health Savings Account.

Vermont's hospitals are already in a state of unpredictability as they emerge from COVID-19. Currently, it is difficult to plan out more than a few months with any certainty. Placing a monumental change in health care and delivery system reform will only increase the instability hospitals are already experiencing.

Protecting 340B Program for Hospitals and FQHCs

In many cases the 340B program makes up a large part of Vermont's hospitals' margins and allows them to keep their doors open. Over the last year, there has been a real attack on the 340B program, to the detriment of FQHCs and hospitals. Most recently, Express Scripts, a pharmacy benefit manager (PBM) has required pharmacies to report every prescription that is filled with a 340B drug within 10 days of filling it—if the pharmacy does not comply with this administrative burden, they risk losing their entire Express Scripts contract.

It is late in the session, but this issue is crucial to Vermont's hospitals and community clinics. Bi-State Primary Care Association and VAHHS would like to add the following language to the OPR bill based on Utah's law:

SEC. X
A pharmacy benefit manager may not:

(a) create any additional requirements or restrictions on the 340B entity; or
(b) require a claim for a drug to include a modifier to indicate that the drug is a 340B drug unless the claim is for payment, directly or indirectly, by the Medicaid program.
(c) restrict access to a pharmacy network or adjust reimbursement rates based on a pharmacy's participation in a 340B contract pharmacy arrangement.