Option	Brief Description
Cost Containment and Value Based Purchasing	
Cost Growth Containment/ Affordability Boards/ Affordability Standards	Utilizing data to understand and define what is affordable for families and individuals earning different incomes and living in different communities allows policymakers to create solutions to ensure health care is more affordable. Instituting affordability standards would help keep policymakers, providers, and insurers accountable for providing care and coverage that is accessible and equitable.
Cost Growth Benchmark	A cost-growth benchmark program is a cost-containment strategy that limits how much a state's health care spending can grow each year. Massachusetts established the first program in 2012. A growing number of states are now using the strategy to contain costs for patients, providers, and payers.
Episodes of Care across all payers	In contrast to traditional fee-for-service reimbursement where providers are paid separately for each service, an episode-of care payment covers all the care a patient receives in the course of treatment for a specific illness, condition or medical event. Maternity is one area where an Episode approach can support savings. There are many other areas where episodes can drive efficiencies. Savings can be realized in three ways: 1) by negotiating a payment so the total cost will be less than fee-for-service; 2) by agreeing with providers that any savings that arise because total expenditures under episode-of-care payment are less than they would have been under fee-for-service will be shared between the payer and providers; and/or 3) from savings that arise because no additional payments will be made for the cost of treating complications of care, as would normally be the case under fee-for-service. Episode-of-care payments also are known as case rates, evidence-based case rates, condition-specific capitation and episode-based bundled payments.
Health insurance rate review	For over a decade, Rhode Island has used its health insurance rate review authority to constrain the growth of hospital prices to the rate of inflation plus one percent. Other states, including Colorado and Delaware, are moving to implement similar strategies giving the insurance commissioner the authority to enforce affordability standards as part of the health insurance rate review process.
ACA Section 1332 Waiver	

Public Option	Under a 1332 waiver, states have access to additional federal funding that could be critical in advancing coverage reforms. Section 1332 can be used to extend eligibility for premium tax credit (PTC) subsidies to public option enrollees even if they would not otherwise qualify — for example, if income is above 400 percent of the federal poverty level or the option is offered outside the state's marketplace. Section 1332 also could allow the state to recapture savings that would otherwise accrue to the federal government. This is known as "pass-through funding" —for example, the federal cost savings that accrue from subsidies because of lower public option premiums would be refunded to states. States can use pass-through funding to defray program costs, enhance benefits, and expand consumer subsidies, among other options.
Reinsurance	Most states (15 out of 16 with federal approval) have leveraged Section 1332 waivers to seek federal approval and pass-through funding for state-based reinsurance programs, which aim to lower health insurance premiums for plans sold in the individual insurance market. A reinsurance program is a reimbursement system that protects insurers from high medical claims for beneficiaries with complex and costly medical needs. It usually involves a third party acting as an insurer for the insurance company by paying part of a claim once it surpasses a certain amount, or by covering part or all of the claims for individuals with pre-determined, high-cost conditions.
Adjusted Plan Options (APO)	The APO waiver concept, if approved for a state, would enable a state to take advantage of the flexibility provided under section 1332 of the PPACA to increase consumer choice and affordability by allowing a state to provide state financial assistance for non-Qualified Health Plans (non-QHPs), allowing non-QHPs to be sold on the existing Exchange, expanding the availability of catastrophic plans beyond the current eligibility limitations, applying PTC to catastrophic plans and potentially certain non-QHPs sold on the Exchange, and/or other approaches. The APO waiver concept encourages states to target solutions to their unique problems or challenges in the individual and small group insurance markets, free from the constraints of certain federal requirements imposed by the PPACA.
State subsidies and service expansion	
Remote Access to Health Care Services	Legislation to require remote access to healthcare services, including telehealth, which may increase participation for those who are medically or socially vulnerable or who do not have ready access to providers. Remote access can also help preserve the patient-provider relationship at times when an in-person visit is not practical or feasible.
Premium and Cost Sharing Subsidies	Vermont could offer subsidies to populations ineligible for federal assistance as a way to provide assistance to populations otherwise left out of state-federal programs. This would be in addition to benefits provided through Vermont public programs today.

Health Equity: Expand VT Blueprint for Health Community Health Teams, including Mental Health and Maternal Health	Vermont could increase the number of mental health providers and care managers available to all participating Blueprint practices, including women's specialty practices to support pre and postpartum patients. These services would be available to all Vermonters, regardless of insurance status.
Enhanced services provided to 'pre-duals '	Home and community-based services (HCBS) help seniors and people with disabilities and chronic illnesses live independently outside institutions by assisting with daily needs. HCBS include but are not limited to home health aide services, assistance with self-care tasks such as eating or bathing, supportive housing, and assistive technology. Providing a modified level of HCBS services to Vermonters not yet eligible for them under current rules may stave off the need for more intensive services in the future, thereby saving Medicaid dollars that would have been spent, in addition to improving current quality of life.
Draft a resolution to encourage the federal government to make temporary ACA premium subsidies permanent	The American Rescue Plan (ARP), recently signed into law by President Biden, increases and expands eligibility for Affordable Care Act (ACA) premium subsidies for people enrolled in marketplace health plans. These changes to marketplace premium subsidies are temporary, in effect only during calendar years 2021 and 2022.
Expand Medicaid to additional income levels for certain ages	Expand access to affordable health care through existing public health care programs or through the creation of new or expanded public option programs, including the potential for expanding Medicaid to cover individuals between 50 and 64 years of age and for expanding Vermont's Dr. Dynasaur program to cover individuals up to 26 years of age to align with the young adult coverage under the Affordable Care Act.
Pharmacy	
Pharmacy Cost Sharing limits / reductions	Vermont could reduce cost sharing for prescriptions and limit the total cost sharing for pharmacy across all payers.
Fines for Unsupported Price Increases	Some drugs with unsupported price increases disproportionately contribute the most to increased spending. States can require manufacturers to pay a penalty based on their sales volume for the identified drug within the state.
Legislation directed at Pharmacy Benefit Managers (PBM)	Legislation to require increased transparency of PBM operations, including shedding light on how they determine the pricing reimbursement of prescription drugs
Transparency and Regulation	

Legislation to prohibit hospital consolidation	Consolidated health systems leverage their market power in negotiations with insurers because the insurer cannot afford to exclude must-have providers from its network. Dominant health systems can use all-or-nothing negotiations to raise prices for all of their affiliated providers by threatening to prevent any of their providers from participating in the insurer's network unless the insurer accepts the prices and terms set by the health system. These types of distorted negotiations between providers and insurers directly contribute to higher costs for states, employers, and patients.
Legislation to prohibit anticompetitive contracting	Vermont can consider options to promote and protect competitive markets including vigorous antitrust enforcement policies, legislative action, and increased oversight of insurance contracts.
Community Benefits Reporting and Charity Care Requirements	The COVID-19 pandemic has impacted state budgets and illuminated racial and ethnic health disparities that recent health improvement efforts have not adequately addressed. It is more important than ever that nonprofit hospitals provide meaningful community benefit investments aimed at least in part on improving health equity in exchange for the large tax exemptions they receive. State leaders have an opportunity to use policy levers that go beyond the federal community benefit requirements to hold hospitals accountable for their commitment to improve community health.
Publish consumer-focused price data	As spending on health care services continues to grow—particularly for hospital, physician and clinical services—state and federal policymakers are leveraging health care price transparency as a potential strategy to curb rising health care costs. Price transparency takes many forms, but the overall intent is to increase consumer knowledge of health care prices. The theory is essentially "knowledge is power"—if a patient has sufficient understanding of the costs for a health service prior to receiving care, they can seek high quality services at the lowest cost. Moreover, lawmakers and other stakeholders can utilize price information to pursue effective cost containment strategies and policies.
Reducing use of low value services	Choosing Wisely (http://www.choosingwisely.org/) is a physician based effort that has been implemented across a number of states that aims to promote conversations between physicians and patients by helping patients choose care that is: 1) supported by evidence, 2) not duplicative of other tests or procedures already received, 3) free from harm, and 4) truly necessary.