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Testimony on S.211
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Overview

S.211 would produce a seismic shift – splintering actually – in our state health care regulation and reform oversight, but not to the benefit of Vermonters. This bill adds a massive increase in complexity and administrative cost by further dividing state health care oversight and does not solve the perceived conflicts between policy and regulatory decisions.

Very few of the provisions in this bill address the main concerns of our citizens – affordability, access to care, and improving the thicket of health care complexity for the patient.

I have heard the desire to separate policy and planning decisions from a single regulatory body. This comes from the criticism of the GMCB being both the cheerleader and the regulator of the ACO. I strongly disagree with the diagnosis of the problem.

The GMBC should not be the “cheerleader” for the All Payer Model or the Accountable Care Organization. Quite frankly, no one should be cheerleading, the very word indicates unquestioned support. If we want these health care reform efforts to succeed in Vermont we need to be constantly vigilant, asking tough questions, and seeking solutions. Cheering has no place.

Strong regulatory oversight is the best way to ensure the success of health care reform in Vermont. For example, our Captive Insurance Division promulgates strong regulatory oversight in order to domicile captives here – it is the opposite of cheering – and captives value the integrity and stability, which are attractive to these businesses and their customers.

Every regulatory process is laden with policy decisions. There can be no artificial division of these roles. Every single GMCB insurance rate decision, hospital budget decision and certificate of need decision is a policy decision. If you want Vermont to work towards its health care reform goals, we need to use the power of coordinated regulatory and policy efforts to move our health care system in the same direction and as a whole. Splitting these decisions among different Agencies of state government and the GMCB will lead to failure. A divided regulatory and policy structure will not help unify our health care system.

The Agency of Human Services is a problematic choice to place these new responsibilities. When I started working here, BISHCA still existed – Banking, Insurance and Health Care Administration from which the GMCB was carved out and given expanded authority. Now we’re proposing a third health care reform entity. This will be costly, inefficient and ultimately ineffective. This will lead to:

- Less transparency and due process at AHS than at the GMCB.
- AHS, through the Medicaid program, is a payer. There is inherent conflict between the interests of government and commercial payers. This has already exacerbated the cost-shift, and without an arms-length regulator keeping a steady downward pressure on the prices being asked of the Vermonters who can’t escape the commercial prices at hospitals.

- The GMCB has been developing a solid bench of staff with deep expertise in hospital budget and rate review and this appears to duplicate these resources at AHS for global hospital budgets.
- DFR is a professional insurance regulator under the guidance of the NAIC and has responsibility for consumer protection, market oversight, insurer solvency, etc. Entities that oversee health insurance need to maintain a connection to this type of national information and support.

While there are a few positive changes incorporated into this legislation, overall the improvements do not outweigh the harm from the shift in health reform oversight.

Section by Section

Section 2 – Mandates that DFR require health insurer participation in the AHEAD model
Blue Cross VT has several concerns with this proposal:

- Blue Cross VT participated in the APM every year from its inception until 2023 when we withdrew due to the lack of tangible quality outcomes, inability to bend the cost curve, and the new data approach that introduced concerns about security and privacy and no longer serving the best interest of our members.

- The AHEAD model and especially the Global Hospital Budgets, if designed well, may contain cost growth in Vermont. The details are extraordinarily important. If it is designed to just continue the current cost trends into the ongoing trajectory, and allow significant exceptions—on drug income, for example, which is a major cost driver for Vermonters' premiums—and other ways to undermine the global budget, then costs will continue to compound at an unsustainable pace.

  The bill would effectively require the GMCB to approve the growth rates determined through AHS' global hospital budget process and no longer have independent decision-making authority. This change undermines the regulatory process and takes the teeth out of the regulator charged by the Legislature to contain system costs.

- The NOFO does say, "States will be expected to leverage available legislative or regulatory authority to hold commercial payers accountable for TCOC growth." Hospitals are also required to participate, yet this bill mandates only payers. Cost growth is driven by hospital care and the cost of drugs. If the goal is controlling costs, the focus should be on the cost drivers.

- This section doesn't give DFR any leeway to truly make decisions based on their expertise. DFR oversees our financial solvency and the stability of the insurance marketplace, but under this new framework this could not be taken into consideration. If there was a significant disruption – such as major cost increases and an increased administrative regulatory layer that would so substantially disadvantage the Vermonters who pay these commercial rates, they would change their health plan in favor of a payer who was not obligated to participate. DFR could not take that into account.

- Is mandating participation going to result in a functional system? If the largest health insurer in the state must participate in any event, do we have any leverage to advocate for the interests of our members and customers? Will our questions and concerns be given adequate consideration? The State must design a system that benefits all Vermonters.

Sections 1 and 3-7 that propose to shift responsibilities between the GMCB and AHS are ill-advised and will further hinder the state's health care reform objectives. Especially the provisions that only allow the GMCB to "*engage in payment and delivery system reform to the extent so directed by the General Assembly or in collaboration with the Agency of Human Services*." This eliminates the independence of the GMCB.

Section 8 – GMCB oversight of Medicare-only ACOs – Blue Cross VT supports.

Section 9 – GMCB mediation of contracts between providers and payers.

- Creates an impossible task and may not be worth the time and resources.
- Payers already notify DFR, who has regulatory authority over contracts, in advance of a termination.
- At least, please include a threshold (an impact 10,000 or more lives). There are numerous contract terminations, some which are for cause, and impact a small number of members with a single provider.

Section 10 – Credentialling and Quality Measures.

Is the concern about the scope of the payer's network or the credentialling process? Typically there is the assumption that all providers who are eligible to participate with Medicare have enrolled with CMS. Recently, Blue Cross VT has found that some qualifying providers have not chosen to enroll with CMS.

NCQA requires insurers to credential providers in order to be certified. Blue Cross VT cannot sell health insurance plans on the Exchange without accreditation.

Additionally, some providers Blue Cross VT credentials that Medicare does not:

- Naturopaths
- Licensed Alcohol and Drug Counselors
- Psychologists
- Board Certified Behavioral Analysts
- Certified Midwives
- Acupuncturists
- Athletic Trainers
- Hearing Instrument Specialist or Hearing Aid Dispensers
- Licensed Genetic Counselors
- International Board-Certified Lactation Consultants (IBCLC)
- Licensed Professional Counselors
- Pharmacist Performing Medication Therapy Management Outside of a Retail Pharmacy Setting

CMS quality measures are focused on the population over age 65. Some examples of non-CMS quality measures that Blue Cross VT believes are important include:

- Child/Adolescent Well-Visit
- Childhood Immunization Status
- Adolescent Immunization Status
- Any additional measures that are for adults under 65 years of age
- All perinatal care, including prenatal and postpartum visits

Section 12 – Hospital Budget Process

Blue Cross VT supports some of these improvements to the hospital budget review such as formalizing the process.

Concerns with this section:

- Excluding fixed perspective payments from a hospital's budget review and dividing the oversight between the GMCB and AHS prevents a comprehensive evaluation of a hospital's total budget including revenue and expenses.
- The language on the benchmarks is overly proscriptive. These criteria are appropriate to include in the hospital budget guidance and includes a transparent process for feedback.

Section 14 – Decorum training for the GMCB

The GMCB must ask tough questions of the regulated entities. The GMCB acts with professionalism. This section is inappropriate.

Section 15 – Population-based hospital budgeting

The State is currently developing global hospital budgets and its application to CMMI for the AHEAD model, of which hospital global budgets will be a key component. The methodology proposals are still in the early stages of development and therefore, these sections seem premature.

In addition to hospital solvency and stability, any statutory language developing global hospital budgets should also include "affordability and the ability of Vermonters to pay for these services.

It appears that the global hospital budgets will be similar to the state education funding system (based on weighted per pupil payment amounts) and will have some of the same challenges – namely that population-based payments will advantage Chittenden County hospitals over rural ones – in education, this was originally solved with small schools grants. The funding of capital expenditures will be also crucial. A population-based payment without appropriate adjustments could and further consolidate care, increase costs and lengthen wait times.

Section 16 – Regulatory Realignment has been studied at the GMCB previously.

Section 17 – AG review of mergers affiliations and divestments

Blue Cross VT continues to be deeply concerned about the infiltration of private equity in the provider landscape. Reporting of private equity investments in the health care system would be a first step towards transparency in this area.

Section 18 – Single State Agency for Health Care Data Coordination

Blue Cross VT does not support the proposal to combine Vermonter's health insurance claims data (VHCURES) and clinical health records (VITL-HIE) into one database.

- Blue Cross VT is deeply concerned with how member's data privacy and security will be impacted, as well as the considerable financial, legal and practical complications.
- The proposal has not clearly articulated what the potential future uses will be, or who will have access to the information.
- At present, there are too many issues with the data for it to improve the quality of care, to be useful for real-time care delivery, or to improve provider decisions in clinical settings.

- The investment of significant premium dollars to create a database for research purposes alone when there are so many other dire needs related to the direct delivery of health care services is a serious concern.
- The multiple and severe data limitations render the entire project of minimal value for health care reform initiatives, providers, payers, or government entities. In short, this is a tremendous cost for a research tool.

Legal/Governance Issues:

- At present, there are multiple entities responsible for collecting, analyzing and projecting the information, but no single entity responsible for the project in its entirety.
- Medicare prohibits access to personally identifiable Medicare claims information that is stored in VHCURES, according to GMCB staff. As a result, at least a third of the records in the proposed database cannot be combined with personal health records.
- The two databases treat mental health and substance abuse data differently. How will this critical information be handled consistently if combined?

Resource Issues:

- The human and financial resources to accomplish this objective will be significant, requiring thousands of hours of time from Vermont's experts in data analytics and development.
- Vermont has already dedicated millions of our scarce health care dollars via the claims tax that has been dedicated to developing health care databases. Ask Vermonters if they want additional multiple millions of their premium dollars to fund a health research project.
- The usefulness of these investments needs to be evaluated prior to dedicating more money to projects with uncertain value to Vermonters.

Privacy Issues:

- A massive database of personally identifiable health care information, no matter how incomplete, has enormous value for unlawful subversive actors. The cybersecurity company Critical Insight released an analysis in February 2023 that nearly 50 million patients in the United States were affected by data breaches of health records in 2022; in just the first six months of 2023 the number of patient's records exposed reached 40 million—the highest on record for a six-month period so far.
- These concerns are echoed in the current legislative debate that wrestles with how to protect Vermonters' data. As is being contemplated with commercial data use cases, Vermonters should be able to opt out of the dissemination of their protected health data. Deliberations about the protection of health data and the protection of commercial data should not be held in silos.

Practical Concerns:

- The current claims information collected by VHCURES is incomplete because of the absence of self-funded employer (ERISA covered entity) or Medicare claims, rendering the entire database project of limited overall value. Further, VHCURES only includes the claims data of Vermont residents.
- The applicability of claims data is limited by the purpose for which it is created. Claims data holds little value for clinical decision making.

Effective Dates: The effective date of this massive reorganization of government provides less than six months for implementation.