

INTERVIEW

Comprehensive Health Care Reform In Vermont: A Conversation With Governor Jim Douglas

Improving population health, achieving universal coverage, and attacking rising health care costs together were the objectives of Catamount Health, a bipartisan effort passed in 2006.

by James Maxwell

ABSTRACT: In this conversation, Vermont's Republican governor, Jim Douglas, discusses his role in and views on the state's comprehensive health reforms adopted in 2006. The reforms are designed to provide universal access to coverage, improve the quality and performance of the health care system, and promote health and wellness across the lifespan. He describes the specific features of the reforms, the plan for their financing, and the difficult compromises that had to be reached with the Democratically controlled legislature. He talks about his need, as governor, to balance the goals of health reform against other state priorities such as education and economic development. [*Health Affairs* 26, no. 6 (2007): w697-w702 (published online 16 October 2007; 10.1377/hlthaff.26.6.w697)]

James Maxwell: Vermont has a long history of health care reform, including expansions of the State Children's Health Insurance Program (SCHIP) and Medicaid expansions instituted by former governor Howard Dean. In the spring of 2006, Vermont adopted perhaps the most comprehensive health care reforms in its history, Catamount Health. Can you describe the key elements of the reform plan enacted in Acts 190 and 191?

Jim Douglas: A couple of months ago, Secretary of Health and Human Services Mike Leavitt talked to me about the comprehensiveness of Vermont's recent reforms, and he mentioned that we did not receive enough recognition for our work. Our reform is very comprehensive and contains elements of financing reform and the promotion of public

health and disease management, and it is designed to improve the overall performance of the health care system.

Catamount Health is a premium-subsidy program that allows the uninsured to purchase affordable coverage through their employer or directly through Catamount. These reforms are a key part of my strategy to make Vermont a more affordable place to live, work, and raise a family. The reforms are part of my Affordability Agenda, which also includes addressing the cost of higher education, housing, and taxes. In addition to Catamount, we have a comprehensive approach to health improvement that includes wellness and health promotion programs across the lifespan as well as a statewide disease management program known as the Blueprint for Health.

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Reaching Political Agreement On Reform

Maxwell: You have been described as a Yankee Republican. What key compromises did you have to make to reach an agreement with the Democrat-controlled state legislature?

Douglas: Both houses were, and are now, controlled by Democrats, so we had to work together and find commonsense solutions. This meant rejecting extremes on the ideological spectrum and finding a compromise that we could all feel comfortable with. Ultimately, we worked together to find the common ground. The middle was between those who wanted a taxpayer-financed, government-run system and those who did not; it includes private insurers to run Catamount but state subsidies to help in financing.

Maxwell: So the policy itself was crucial to the compromise? What about political leadership?

Douglas: One of our most important partners was Peter Welch, the leader of the Vermont Senate and now Vermont's U.S. congressman. It was clear to me that he wanted to accomplish something and to get a bill that we could all feel good about. In his congressional campaign, he touted his ability to work with a Republican administration as a key highlight of his state Senate experience. Another legislator said that we all needed to come out of our comfort zones in adopting this legislation.

Maxwell: In 2005 you decided to veto the health care reform bill sent to you by the legislature. What accounts for the different results in 2006? How do you think your veto influenced the debate in 2006?

Douglas: Well, it clearly established some parameters and a point beyond which I was not willing to go in terms of the structure of the reforms, and especially the financing. The legislation in 2005 had new payroll taxes, which were inappropriate for a state with a high tax burden. I think the veto made it clear that I wasn't going to significantly increase the tax burden.

Knowing that this issue would come up again in the next session, that summer we set in motion a number of public gatherings and a summit where we had speakers, and some NGA [National Governors Association] support, and we invited Democrats and tried to get off on the same foot together.

Financing The Reforms

Maxwell: Financing of coverage expansion has often been a key obstacle to state health care reforms. How are the Catamount Health reforms financed, and how were the affected parties able to reach agreement on financing?

Douglas: As I indicated in 2005, I would not support higher payroll taxes. But I did agree in 2006 to higher cigarette taxes of sixty cents per pack. This made sense to me, as we want to discourage smoking through our health care reform plan. There is also an employer assessment—one dollar per day for each uninsured employee. I didn't support the assessment, but it was part of the compromise. Because of the burden on employers of part-time and seasonal workers, we are considering legislation that would exempt these workers. The Vermont program is also financed through coverage expansions of the state Medicaid program and the state's general revenues.

Why Not An Individual Mandate?

Maxwell: Massachusetts adopted an individual mandate as part of its health care reform plan. This type of mandate was also discussed in Vermont. What do you think about this idea, and why did you not support it in 2006?

Douglas: As the late Gov. Richard Snelling said, "Vermonters will do almost anything you ask them to and almost nothing you tell them to do." We have most people covered by health insurance already; an individual mandate would not get us to universal coverage in this state. For example, most people have car insurance, but not all do, even though it is mandated. It is better to reach out to the uninsured

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population and encourage and enable them to be insured by providing affordable options.

Message To Critics

Maxwell: There are some people in Vermont, especially supporters of a single-payer system, who think that Catamount Health did not move quickly enough to universal coverage. What do you say to members of these groups when you meet with them?

Douglas: First of all, I assure them that my goal is the same as theirs, in that we want universal coverage; we want everyone to have access to care. What I explain is that our Medicaid program had a projected 13 percent increase each year, until we got the Global Commitment [Section 1115 Medicaid Waiver].¹ And if we had those kinds of increases for everyone (under universal coverage/state single payer), it could bankrupt our state.

Again, it comes back to cost control. I've often said that we need to bend the cost curve; if it is payment reform without bending that cost curve, it is not helpful. This is critical, because in one sense it doesn't matter which pocket the money comes out of. If we don't reduce the cost of care, all of our pockets are going to be empty.

Specific Features Of The Reform Plan

Maxwell: There were two reforms designed to make coverage accessible to those whose family incomes are below 300 percent of the federal poverty level, but who are not eligible for Vermont's Medicaid program: a subsidized insurance product, and subsidies to purchase employer-sponsored insurance. Can you explain the key elements of these reforms?

Douglas: The new health plans under Catamount and the subsidies for employer coverage will be available beginning this month. The goal is to ensure that everyone has access; we feel strongly about this. The state shouldn't have the responsibility if an affordable alternative is available; we will help someone purchase

coverage through their employer, a requirement that is entirely reasonable. The problem with our current system is that it is a cliff eligibility system: If you make a dollar more than the eligibility cutoff, you get no coverage. We don't want to discourage people from earning more in order to maintain their health insurance coverage. Also, above 300 percent of poverty, Catamount Health will be a better product than the unsubsidized options we have now.

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Maxwell: In the midst of the legislative session last year, new data were released showing that nearly 50 percent of the uninsured were eligible for Vermont's relatively generous Medicaid program, which allows working adults with incomes up to 185 percent of poverty to enroll. How did these new data on the Medicaid-eligible uninsured affect the public policy debate?

Douglas: We have always known that many of the uninsured are eligible for Medicaid but not enrolled. We have long had programs to reach out to the Medicaid-eligible population—through PSAs [public service announcements], case-worker interventions, checking in to see if folks are eligible. Vermont also has one of the highest SCHIP participation rates in the country. Nevertheless, we need to do even more to encourage people to enroll. Our new director of health reform implementation, Susan Besio, is responsible for ensuring that this happens.

Maxwell: How do Catamount Health and the premium assistance program intend to stay within the global cap on expenditures that Vermont negotiated with the Centers for Medicare and Medicaid Services (CMS)?

Douglas: I said a couple of years ago to the legislature that our goal is to save Medicaid first, as we were on an unsustainable track. We are number one in coverage but were facing a shortfall of \$600 million over a five-year period. We worked hard to come up with the Global Commitment, which gave us more flexibility in exchange for a lower rate of increase. It is a managed care strategy to work with our Medicaid population and to work with those

individuals in terms of what is going on with their lives. This individualized strategy is one advantage of being in a small state.

Maxwell: The coverage expansions were combined with disease management and health promotion programs targeted both to the Medicaid population and to Vermont's health care system as a whole. Can you describe the reforms described as the Blueprint for Health and why you believe that they are so important?

Douglas: We have taken a comprehensive approach to health promotion and disease management. We have wellness and health promotion strategies across the lifespan, a "healthy choices" discount for health insurers where they can give a discount on health insurance for healthy behavior, a goal of free immunizations for everyone in the state, a new healthy aging commission, and a workplace wellness program. The Blueprint for Health focuses on developing a statewide approach to chronic disease management, with supports for providers, patients, and communities in this systemic effort. The initial focus of the Blueprint is diabetes, but we will move on to other diseases. The Blueprint is a unique partnership of the state, the health care provider community, and insurers in the state. We just had our annual Blueprint conference, and this entire community is excited and working hard to make it succeed. I'd like to pick up the pace a little, but it is the right thing to do.

We are going to work with some fitness programs, and we have a state employee pedometer program for those who walk the most. As a result of these efforts, we have kept premium increases for state workers in low single digits. This is critical. I feel very strongly about the approach.

Disease Management For Medicaid

Maxwell: With these reforms, Vermont joins the small number of states that adopted disease management programs targeted to their

Medicaid populations. What does Vermont intend to do in this area, and why do you think that it is useful?

Douglas: Medicaid costs are high, as I mentioned. The participation rate is high, costs are increasing at a high rate, we cover a lot of optional services, and chronic disease may be responsible for up to three-quarters of the health care costs in the program. If we want to get a handle on Medicaid, it has to be focused on chronic disease. Given the size of our state, this

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is critical, and we need to look at how much each participant is costing the state—who is using the most resources. Through a contract with a specialized disease management vendor, we are assigning

a social worker and nurse to these folks to bring up quality and bring down the cost. I've often said that what we currently have is not a health care system—this is a sick care system. By the way, the Medicaid disease management program is also aligning with the Blueprint for Health principles so that we will have one integrated approach across all providers and payers in the state.

Health Promotion And Disease Prevention

Maxwell: The reforms also contained a commitment to disease prevention and health promotion across the lifespan. Can you explain why you are so personally interested in this aspect of health reform?

Douglas: First, Vermont is a place of unparalleled natural beauty, and our residents and tourists want to enjoy the outdoors, good air, lakes, streams, and ski slopes. So in terms of quality of life, it is important to be healthy. The Affordability Agenda is also critical. Vermont's economy is still growing at a very modest rate. Many people are moving away because living here is expensive, so we need to attack the cost of living. Housing costs are high; higher education cost is high; taxes are high. And the Affordability Agenda is working to address these critical areas and make Vermont a more affordable place to live and work.

Implementation Status Of Health Reform

Maxwell: The Vermont legislature established very tight deadlines for many parts of this health reform program. Can you describe the accomplishments of the program so far?

Douglas: Some of the most immediate consequences have been to sensitize people to be aware of costs, take care of themselves, and take charge of their health. It is each person's responsibility to take care of themselves. The focus on wellness and immunizations and disease management is greater than ever in this state. We recently sponsored a contest on three themes: exercise, nutrition, and tobacco (the core of our Fit and Healthy Vermonters initiative).² If our next generation is more sensitized to these responsibilities, we will be in good shape.

Another consequence is that we've gotten to the point in Vermont where we have few insurers. One new one hopes to come into the market to offer the new Catamount Health plan.

Maxwell: What do you think are the major obstacles or challenges Vermont is facing in implementing health reform?

Douglas: Tackling such a broad area where we are simultaneously trying to address health care quality, cost, and access. The reform legislation that was signed into law last year has over thirty-five initiatives that all tie to these three goals, and we have state staff and partners working diligently to bring them all to fruition. But it will take time, and I worry that people may want to move on to further efforts before our current activities can take hold. That would be a mistake.

Lessons For Health Policy Reform

Maxwell: Comprehensive health reform takes political leadership and the willingness to assume political risks. Did you have a vision of how you and other senior members of your administration should promote health reform in

2006? What credit do you give to the leadership of the Democrat-controlled legislature?

Douglas: I had several elements in mind: not increasing the tax burden; secondly, cost containment in public programs; and finally a shift of the focus away from delivering health care services care to a preventive strategy of maintaining one's health to the greatest extent possible—more of a public health focus than simply insurance and financial reform. I would give much credit to my Democratic col-

leagues—it took both parties, and in the end the legislators saw that we had to abandon the extremes.

Maxwell: Moderate Republican governors have been taking the lead on state health reform in Vermont, Massachusetts, and now California. Do you have any explanation for this phenomenon?

Douglas: My Republican colleagues see the same challenges: control the cost of government, provide universal coverage, and continue to move the economy forward. Key challenges in any state are providing employers with affordable health insurance options and the tools to maintain a healthy employable population at a time when demographics are working against us (many states have an aging workforce). There is a need for practical solutions to these problems.

Maxwell: Why did you feel that Vermont needed to act on its own instead of waiting for health care reform at the national level?

Douglas: It was clear that solutions to our most pressing health care challenges had to come from the states. Vermonters, and many other Americans, are tired of waiting for Washington to get its act together on this issue. A commitment to meaningful, bipartisan reform can be forged at the level of state governments. So, in the absence of federal leadership on this issue, what we need from our federal partners is the necessary flexibility.

Maxwell: State health reform is linked to federal health policy, especially through Medicaid and Medicare. Did federal policy by the CMS

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facilitate or constrain Vermont's actions? What could the CMS do to make it easier for states like Vermont to promote comprehensive health reforms?

Douglas: The CMS has been helpful in approving our Global Commitment, but they could always do more to facilitate strategies such as ours. Secretary Leavitt deserves credit for working toward providing us the flexibility we needed to be successful. I've met with him several times to talk about this. The secretary has also talked about grant programs to help states figure this out. The question is, How do we do that in a budget-neutral environment?

Maxwell: What do you believe are the key lessons from Vermont's experience for other states?

Douglas: Proportionately, we still do well on coverage compared with many other states. The problems are similar, though: The challenges of maintaining a viable workforce, keeping the state fiscally sound, and encouraging good health are universal across states. One key lesson is that everyone needs to work together; abandon extreme positions; and find a responsible, pragmatic approach that combines financing reform with clear public health objectives.

Maxwell: What's next for Vermont? Is there a need for any mid-course correction?

Douglas: First, we need to see how this transition goes. Enrollment in Catamount Health begins this month [October 2007]. An assessment will be done in 2009 to determine how this is going; we don't want to take a step that is unsustainable, which is one of the commitments of the measure that we passed.

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JSI Research and Training Institute is a nonprofit research and consulting organization with offices in Boston, Massachusetts; Burlington, Vermont; Denver, Colorado; and other states. James Maxwell served as a senior adviser and consultant to the Douglas administration prior to and during the 2006 Vermont legislative session.

NOTES

1. Vermont obtained a Section 1115 Medicaid waiver in late 2005 known as the Global Commitment. For an explanation, see J. Guyer, "Vermont's Global Commitment Waiver: Implications for the Medicaid Program," April 2006, <http://www.kff.org/medicaid/upload/7493.pdf> (accessed 13 September 2007).
2. See the Fit and Healthy Vermonters home page, <http://healthvermont.gov/fitandhealthy.aspx>.