



# Vermont Health Policy Perspectives

November 2006

Vermont Association of Hospitals and Health Systems • 148 Main Street • Montpelier, Vermont 05602 • 802-223-3461

## President's Message: The Business Case for Ending the Cost Shift

With the recent passage of Catamount Health and other health reform laws, unprecedented efforts are well underway to help bring these new laws into practice. Nobody, however, said transformation would be easy. All of these efforts and proposed changes are the first step on a multi-year path that Vermont must maintain in order to realize the vision of a high quality, financially stable, comprehensive health delivery system accessible to all Vermonters.

A key fault in our existing financial structure is the growing imbalance between government underpayments for Medicaid services and private sector over-payments for health insurance premiums. This imbalance is commonly known as the cost shift. Over the next fiscal year, Vermont businesses and their workers will absorb almost \$195 million in health care costs that have been passed on to them. Underpayments from both the federal and state government make up the lion's share of this hidden tax: \$66.6 million from the federal Medicare program and \$89.7 million from the state-run Medicaid program. The remaining \$38.8 million of the cost shift comes from caring for Vermonters who either don't have insurance or cannot pay their deductibles and co-pays. Of this, \$15.5 million is from the uninsured – a problem that will begin to be addressed by the under-construction Catamount Health.

Our focus here in Vermont should be on the Medicaid component of the cost shift because it's the largest part. It's growing rapidly and, unlike Medicare, it's a problem the state can and should address.

So, how do we fix it? There are two basic strategies – slow the rate of growth and require the state to fully fund the Medicaid program. Steps toward the first strategy are already underway. Efforts such as the Blueprint for Health pilot projects, community outreach, payment reform, and preventive care initiatives should gradually begin to produce a slower rate of growth. The second strategy is a matter of resource allocation – in its own way just as difficult, but much more simple to implement. This strategy would require the state to close the \$89.7 million gap between what the

Medicaid program costs and what they pay for the services provided.

Coming up with these new and continuing revenues would be immensely difficult, but it makes good economic sense. Every dollar that the state pays for Medicaid services, the federal government matches with \$1.43. This means that it would only take \$48 million in new state revenue to close the otherwise \$89.7 million gap. That's \$41.7 million that we wouldn't have to raise here. In addition, employers and their employees are already paying for the Medicaid cost shift as part of their insurance premiums, it would be much better for them if that burden were spread across the broader base of taxpayers across the country.

Without bold action, health care costs for the private sector will continue to grow at double digit rates. Balancing and improving our financial infrastructure now must become our top priority. If we don't address the crippling imbalance between how the public and private sectors manage the demand for health care services and pay fairly for that demand, we will never be able to achieve our vision.

This year, industry regulators allowed hospitals to increase their prices to commercial payers by 6.6%. The Medicaid cost shift was a significant component of hospital rate increase requests. In making his decisions, the Commissioner acknowledged the cost shift.

“The hospitals' pricing includes the need to recover additional revenues from some payers because of bad debt/charity care and

*(Continued on back)*

### ALSO IN THIS ISSUE:

- Paving the Way: From planning to implementation
- Mercury Legislation



## PAVING THE WAY: FROM PLANNING TO IMPLEMENTATION

**T**hankfully, Vermont's road construction season is drawing to a close, but for health care, the work never stops. Vermont's hospitals are continually doing their part to help create a high quality, financially stable, comprehensive health delivery system accessible to all Vermonters.

It has been almost four months since several new health care laws were passed. The centerpiece of this legislation seeks to create Catamount Health, a private market solution to covering uninsured Vermont residents. Many challenges lie ahead for Catamount Health, but other legislation will more immediately effect hospitals. Member hospitals and Association staff have already logged hundreds of hours on work related to the implementation of the Blueprint for health, common claims procedures, safe apology/sorry works, adverse events reporting, and information technology to name a few.

It's just starting to sink in how hard it will be. At its best, making system-wide improvements is a two-step forward, one-step backward policy process. Our current health care system evolved over decades and many of the proposed solutions are inter-related, very detailed, labor-intensive and of course, expensive. One over-arching challenge has been and will continue to be how to best orchestrate these new efforts in a way that will create non-duplicative, efficient, affordable and sustainable improvements.

Change often requires untangling decades of complicated, entrenched, and inextricably intertwined policies and practices. As one example, Vermont Information Technology Leaders is working to create a path toward a state-wide "electronic" health care system. This work has already taken months and new laws around respective liabilities and immunities will likely be needed before this phase of the construction can be completed. VITL has just signed a five year contract with General Electric and the Vermont Department of Health. While this is a huge milestone, it has taken much longer than originally planned.

Delays with VITL's efforts will impact the progress of others. The VITL delay will likely hold up the HIT tools slated for physicians as they work to incorporate practice changes aligned with the states' chronic care initiative – the Vermont Blueprint. This could impact physician participation and as such slow the Blueprint's progress, which in turn will have

implications for other related efforts like payment reform.

There's no guide book for the work that Vermont is currently undertaking and there's not much new money to fuel this innovation either. To the state's credit, there has been a significant investment of public resources, but federal funds will be needed as well. We also know that with our aging population, demands for health care will continue to increase. Even with more "system-ness", less waste and improved care all the way around, will health care still be too expensive? If so, what will we be willing to give up? Will we be willing to trade our current system of rationing for a new one? These questions and many more will continue to be part of our health policy environment for years to come. We all hope these efforts will make health care less expensive. Vermont's history of collaboration, optimism and leadership will help, but we will face many challenges and tough decisions as we break new ground.

### **Important Legislative Deadlines Coming Up**

#### **December 2006**

- Cost shift task force to make recommendations regarding administrative or statutory changes
- Secretary of Administration to produce a five year strategic plan for implementing Vermont's health care reform initiatives

#### **January 2007**

- Common Claims interim report due
- Agency of Human Services shall develop an implementation plan for prevention and management of chronic conditions
- The Commissioner of Disabilities, Aging, and Independent Living shall report on the future of nursing homes and Medicaid reimbursement rates for nursing homes.

#### **March 2007**

- Deadline for healthplans to file rates and forms for Catamount Health



## MERCURY LEGISLATION IMPACTS HOSPITALS

In 2005, legislation was passed in Vermont (10 V.S.A., Chapter 164 §7105) that bans the sale of certain mercury-added products\*. In addition to avoiding a public health threat, the phase-out or elimination of mercury containing products and devices means that there will be less need to provide specialized training and to finance equipment for mercury spills and cleanup.

### Hospital Mercury Reduction Plans

Hospitals are required to develop mercury reduction plans for all owned and operated patient sites. The plan is to set target mercury use reduction goals for mercury-added equipment and chemicals related to patient care and identify measures to be taken to reduce mercury use in these products and materials. Originally, plans were due in 2006; however, the Department of Environmental Conservation has not completed the planning guidance. Plans will most likely be due in 2007 and are to be updated every three years. Hospitals that have significantly reduced mercury use by 95% or more can be exempted from the plan requirement.

### Proper Disposal of Mercury-Added Products

No mercury-added products can be placed in the regular trash. For proper disposal check with hospital equipment suppliers for no cost take-back programs or contact your local solid waste management district or municipality for collection and recycling options in your area.

For questions to any of the mercury legislative or disposal requirements, contact 1-800-974-9559 or visit us on the web at [www.mercvt.org](http://www.mercvt.org).

\* There is an exemption from the ban on sale of mercury-added replacement parts for existing equipment that was in place prior to January 1, 2007.

### The following products are commonly used in hospitals and have been banned from sale:

#### After July 1, 2006:

- Mercury-added fever thermometers and thermostats cannot be sold in the state. This applies to thermostats used for the control of space heating and cooling, but does not apply to fever thermometers with button cell batteries.
- Elemental mercury can only be sold in Vermont if it is used for medical or research purposes. The seller must provide a MSDS sheet to the purchaser and the purchaser or recipient has to sign a statement certifying its use. You can download a form at [www.mercvt.org/manreq/forms/elementalcert.doc](http://www.mercvt.org/manreq/forms/elementalcert.doc)

#### After January 1, 2007 the following mercury-added items are banned from sale:

- Switches (hospital beds and wheel chairs for tip-over safety purposes)
- Relays (commercial ovens)
- Barometers
- Esophageal dilators, bougie tubes, or gastrointestinal tubes
- Flow meters
- Hydrometers
- Manometers (other than a dairy manometer)
- Sphygmomanometers (blood pressure cuffs both stationary and mobile)
- Thermometers that contain elemental mercury other than mercury fever thermometers. (such as lab thermometers)

## Save the Dates!

March 1-2, 2007

VAHHS/VONL Nursing Summit  
Killington Grand - Killington, VT

March 14, 2007

(Please note the change of date. It was March 15)

“Hospital Day” at the State House  
State House Cafeteria



## President's Message *(Continued from front)*

the underpayments by Medicare and Medicaid. This pricing results in Commercial insurance companies paying more than they would otherwise. However, reducing or eliminating the cost shift does not lower or change the total amount of hospital expenses. The cost of labor, capital, and services that the hospitals purchase will remain the same even if the cost shift is eliminated. These are the costs we suggest the hospitals examine to lower the overall demand on net revenues that come from premiums paid by Vermonters, the business community, self insured individuals, Medicaid and Medicare.”<sup>1</sup>

Hospitals are doing their part to hold down their expenses even in light of across the board labor shortages; rising energy costs and increasing patient demand. To help keep their expenses in check, hospitals utilize strategies like group/volume purchasing; work-process improvement for efficiency and error reduction; staff mix evaluation; and continual monitoring of productivity measures.

We welcome the opportunity to lead policymakers and the public in a conversation about what we would like our health care system to look like. Nonetheless, as we work together to lower costs and make health care more affordable for all Vermonters, all options should be on the table, including the notion that the state should pay for all the programs they have promised.

### (Footnote)

1 -From a letter dated October 2, 2006 from BISHCA Commissioner John Crowley to Vermont hospital CEOs.



**Vermont Association of  
Hospitals and Health Systems**

148 Main Street, Montpelier, Vermont 05602

Bulk Rate  
U.S. Postage  
PAID  
Permit #118  
Montpelier, VT  
05602

