



STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: James Reardon, Commissioner of Finance & Management
From: Nathan Lavery, Fiscal Analyst
Date: October 25, 2010
Subject: JFO #2465

No Joint Fiscal Committee member has requested that the following item be held for review, and the remainder of the 30 day review period has been waived:

JFO #2465 — \$48,020 grant from the Commonwealth Fund to the Legislature – Health Care Reform Commission (HCRC). These funds will support health care design study by providing funding for the modeling of 1) the baseline scenario showing the impact of federal health care reform and 2) a macroeconomic impact of each design option on Vermont's economy.

[JFO received 10/12/10]

The Governor's approval may now be considered final. We ask that you inform the Secretary of Administration and your staff of this action.

cc: James Hester, Director

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)



BASIC GRANT INFORMATION				
1. Agency:	Vermont State Legislature			
2. Department:	Health Care Reform Commission			
3. Program:				
4. Legal Title of Grant:	Enhanced Modeling of Baseline Federal Reform and Impact on Vermont Economy			
5. Federal Catalog #:				
6. Grant/Donor Name and Address:				
The Commonwealth Fund, 1150 17th St. NW, Suite 600 Washington, DC 20036				
7. Grant Period:	From:	10/1/2010	To:	2/1/2011
8. Purpose of Grant:				
Fulfill requirement of Act 128 of 2010 (Section 6) to design and evaluate three health reform options. Act 128 directed the HCRC to seek additional grant funding to support enhanced modeling work in the analysis. This grant provides the support for modeling of 1) the baseline scenario showing the impact of the Federal Affordable Care Act and 2) macro-economic impact of health reform on the state's economy.				
9. Impact on existing program if grant is not Accepted:				
Enhanced modeling will not be done.				
10. BUDGET INFORMATION				
	SFY 1	SFY 2	SFY 3	
Expenditures:	FY 2011	FY	FY	
Personal Services	\$48,020	\$	\$	
Operating Expenses	\$	\$	\$	
Grants	\$	\$	\$	
Total	\$48,020	\$	\$	
Revenues:				
State Funds:	\$	\$	\$	
Cash	\$	\$	\$	
In-Kind	\$	\$	\$	
Federal Funds:	\$	\$	\$	
(Direct Costs)	\$	\$	\$	
(Statewide Indirect)	\$	\$	\$	
(Departmental Indirect)	\$	\$	\$	
Other Funds:	\$	\$	\$	
Grant (source)	\$48,020	\$	\$	
Total	\$48,020	\$	\$	
Appropriation No:	1210002000		Amount:	\$48,020
				\$
				\$
				\$
				\$


State of Vermont
 Department of Finance & Management
 109 State Street, Pavilion Building
 Montpelier, VT 05620-0401

[phone] 802-828-2376
 [fax] 802-828-2428

Agency of Administration

STATE OF VERMONT
FINANCE & MANAGEMENT GRANT REVIEW FORM

Grant Summary:		Commonwealth Fund support for design and evaluation of health care reform.			
Date:		10/06/2010			
Department:		Legislature - Health Care Reform Commission			
Legal Title of Grant:		Enhanced Modeling of Baseline Federal Reform & Impact on Vermont Economy			
Federal Catalog #:		NA			
Grant/Donor Name and Address:		Commonwealth Fund, Washington, D.C.			
Grant Period:		From:	To:		
		10/1/2010	2/1/2011		
Grant/Donation		\$48,000			
	SFY 1	SFY 2	SFY 3	Total	Comments
Grant Amount:	\$48,020	\$	\$	\$48,020	
Position Information:		# Positions	Explanation/Comments		
		0			
Additional Comments:		Funding enables enhanced modeling.			
Department of Finance & Management		 10/6/10		(Initial) <i>DB</i>	
Secretary of Administration		 10/6/10		(Initial) <i>10-6-10</i>	
Sent To Joint Fiscal Office				Date	

RECEIVED
 OCT 18 2010

JOINT FISCAL OFFICE

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

		\$
		\$
		\$
	Total	\$ <u>48,020</u>

PERSONAL SERVICE INFORMATION

11. Will monies from this grant be used to fund one or more Personal Service Contracts? Yes No
 If "Yes", appointing authority must initial here to indicate intent to follow current competitive bidding process/policy.
 Appointing Authority Name: Jim Hester Agreed by: JH (initial)

12. Limited Service Position Information:	# Positions	Title
Total Positions		

12a. Equipment and space for these positions: Is presently available. Can be obtained with available funds.

13. AUTHORIZATION AGENCY/DEPARTMENT

I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless previous notification was made on Form AA-1PN (if applicable):	Signature: <u>[Signature]</u>	Date: 9/30/2010
	Title: Director, Health Care Reform Commission	
	Signature: <u>[Signature]</u>	Date: <u> </u>
	Title: <u> </u>	

14. SECRETARY OF ADMINISTRATION

Approved: (Secretary or designee signature) [Signature] Date: 10/6/10

15. ACTION BY GOVERNOR

Check One Box: Accepted (Governor's signature) [Signature] Date: 10/7/10
 Rejected

16. DOCUMENTATION REQUIRED

Required GRANT Documentation	
<input checked="" type="checkbox"/> Request Memo	<input type="checkbox"/> Notice of Donation (if any)
<input type="checkbox"/> Dept. project approval (if applicable)	<input checked="" type="checkbox"/> Grant (Project) Timeline (if applicable)
<input checked="" type="checkbox"/> Notice of Award	<input type="checkbox"/> Request for Extension (if applicable)
<input type="checkbox"/> Grant Agreement	<input type="checkbox"/> Form AA-1PN attached (if applicable)
<input type="checkbox"/> Grant Budget	

End Form AA-1

OCT 01 2010

Beatty, David

From: Nathan Lavery [nlavery@leg.state.vt.us]
Sent: Wednesday, October 06, 2010 11:03 AM
To: Beatty, David
Subject: Small grant proposal for enhanced modeling

In fact, you were copied on this email. Commonwealth apparently doesn't provide an "Award Letter" in the way we typically encounter them. So this email should be considered confirmation of the award.

>>> "Heather Drake" <HD@CMWF.org> 10/5/2010 4:22 PM >>>
Hi Jim:

We just received word the your proposal has been given final approval by the Chair of our Board.

We will get you the Letter of Agreement and Payment and Reporting Schedule to you as soon as we can.

Thank you,
Heather

-----Original Message-----

From: Jim Hester [mailto:jhester@leg.state.vt.us]
Sent: Tuesday, October 05, 2010 2:02 PM
To: Stuart Guterman
Cc: Heather Drake; Nathan Lavery; David Beatty
Subject: RE: Small grant proposal for enhanced modeling

Stu/Heather,
Could I get some form of confirmation (e mail is fine) that the final sign off has occurred? We are processing the internal paperwork to accept the grant and can't proceed until we have this confirmation.
Thanks.

Jim

Jim Hester PhD
Director
Health Care Reform Commission
14-16 Baldwin St
Montpelier VT 05633
802 828-1107 (o)
802 734-1649 (cell)
jhester@leg.state.vt.us

>>> "Stuart Guterman" <[SXG@CMWF.org](mailto: SXG@CMWF.org)> 9/27/2010 9:51 PM >>>
Hi, Jim--

We had our small grants review meeting this afternoon, and I'm glad to report that the staff decided to go ahead with your project. The

MEMORANDUM

To: Rep. Michael Obuchowski, Chair, Joint Fiscal Committee
James Reardon, Commissioner of Finance & Management

From: James Hester, Director, Health Care Reform Commission

Date: September 30, 2010

Subject: Expedited review request

JAH

The Health Care Reform Commission (HCRC) respectfully requests that Finance and Management and the Joint Fiscal Committee expedite their respective reviews of the grant from the Commonwealth Fund for Enhanced Modeling of Baseline Federal Reform and Impact on the Vermont Economy.

HCRC was notified of this award on September 27, 2010. Expedite review is necessary because the grant period is short and begins on October 1, 2010, with the initial payment from the foundation due 10/15.. Below is a timeline of activities that reflect the condensed nature of this project, including the expectation that work will begin in early November.

10/5/2010	Executed Letter of Agreement
10/15/2010	Check for \$38,416
10/22/2010	Draft subcontracts with Thomas Kavet and Dr. Nicolas Rockler
11/5/2010	Executed subcontracts with Thomas Kavet and Dr. Nicolas Rockler
11/30/2010	Update on modeling of baseline case and macroeconomic modeling
12/31/2010	Draft supplementary chapters on modeling enhancements
2/1/2011	Final supplementary chapters on modeling enhancements
3/1/2011	Final financial report for period (10/1/10-2/1/11)
3/15/2011	Check for \$9,604, dependent upon actual expenses

Design of Three Options for Starewide Health Care Reform in Vermont:
Proposal for
Enhanced Modeling of Baseline Federal Reform and Impact on Vermont Economy
Project Director: James Hester Jr. Ph.D.
Health Care Reform Commission, Vermont General Assembly
Proposed Grant Amount: \$48,000
Project Period: 10/1/2010 to 2/1/2011

Background

Since 2006, Vermont has been implementing a comprehensive set of health care reform initiatives with the goals of reducing the number of uninsured residents in the state, accelerating the implementation of health information technology and transforming the health care delivery system to improve its performance and slow the rate of increase in medical costs. Act 191, the original health reform legislation passed in 2006, has been enhanced each year with additional legislation which built on existing efforts and added new programs. In the last eighteen months the Health Care Reform Commission, other legislative staff and standing health policy committees of the House and Senate have had the additional task of following the Federal health reform debate, attempting to share the lessons learned in Vermont and assessing how the new Federal health legislation, the Affordable Care Act or ACA, will affect Vermont. As a result of this work at both the Federal and state level, in its 2010 session the Vermont General Assembly passed Act 128, the latest link in the five year chain of state legislation.

Act 128 continued the process of incremental state initiatives and acknowledged the Federal efforts, but concluded that a more fundamental review of health care reform options was needed to create the framework for long term reform. It spelled out the goals and principles of meaningful health care reform and funded a major effort to design three alternative large scale health system options for Vermont (Attachment 1). One option is based on the single payer model, one is based on a public option, and the third is designed by the consultants. The intent is to create a larger scale state framework which integrates the planned Vermont and federal reforms and provides a working design for a more complete health system reform. In particular, the designs will include sufficient detail to move beyond the rhetoric which has dominated the health reform debate and provide the legislature with specific information to inform its debate about how to move Vermont forward from its current state.

Act 128 requires that each of the three design options is quite comprehensive in scope and should include

- (1) a payment system for health services which includes one or more packages of health services providing for the integration of physical and mental health; budgets, payment methods, and a process for determining payment amounts; and cost reduction and containment mechanisms;
- (2) coordinated regional delivery systems;

- (3) health system planning, regulation, and public health;
- (4) financing and estimated costs, including federal financings; and
- (5) a method to address compliance of the proposed design option or options with federal law.

The schedule for this project is quite aggressive. The draft report with three designs is due 1/1/11 and the final report is due 2/1/11 so that the legislature can consider them next session. The commission administered a competitive RFP process and selected a team led by Professor William Hsiao of Harvard to do the designs. His proposal addressed each of the five components of the design using a combination of economic modeling, stakeholder interviews and analysis, and staff analysis. Act 128 provided \$300,000 in state general funds to support the project.

Project Description

Act 128 encouraged the Health Care Reform Commission to seek external grant support to build on the state funded work plan. After consulting with Commonwealth Fund staff, we are submitting this proposal for a small grant to strengthen the economic modeling for the design.

Act 128 requires an estimate of the total costs, the costs to Vermont state government and the distributional impacts of each of the three design options. Dr Hsiao proposed to subcontract with Dr. Jonathan Gruber of MIT to use the Gruber Microsimulation Model (GMSIM) for this analysis. Dr. Gruber has developed this model over the last decade and it has been widely used to estimate the impact of health reforms on costs and insurance coverage at both the national and state levels. Since Vermont has state level data from its own health insurance surveys (Vermont Household Health Insurance Survey), Dr. Gruber will recalibrate the GMSIM using this more detailed information instead of state estimates from the Current Population Survey. In addition he will have access to the state wide all payer claims data base (VHCURES) which currently has complete data for 2007 and 2008, as well as the annual expenditure analysis which tracks total health care expenses within and outside the state for all residents. The state funding will support this work and the analysis of the three design options

We are requesting support for two enhancements to the planned economic modeling. Dr Hsiao would be the Principle Investigator for the enhancements and ensure that they were coordinated with each other and integrated effectively into the overall design. Dr. Hester as Project Director would amend the existing contract between the Health Care Reform Commission and Dr. Hsiao to include these two enhancements.

- 1) **Enhanced modeling of baseline case:** The impacts of the three proposed design options will be compared to a baseline case which continues the existing Vermont health reform initiatives and phases in the Federal health care reforms in the Affordable Care Act (ACA). Because of funding limitations, the Dr. Hsiao was not able to use the GMSIM for this analysis of the baseline case and instead planned to make subjective estimates using state and national experts. We believe that the analysis would be greatly enhanced by expanding Dr. Hsiao's subcontract

to Dr. Gruber to add a fourth, baseline case to the GMSIM simulations so that we could have a more accurate estimate of the state's starting point. In addition, this baseline analysis would be extremely valuable to the state agencies which are planning for the implementation of ACA and need to estimate its effect on total costs, the state's share of those costs, insurance coverage and distributional impacts. Approximately 150,000 residents, or 23% of the state's population, are currently enrolled in state funded health insurance programs and ACA should have a significant impact on both enrollment and the state's costs.

- 2) **Macroeconomic modeling:** One of the major concerns about the impact of health care reform and changes in the financing of health care coverage is the potential impact on the state's economy. Assessing these impacts requires a macro-economic model of the economy which is completely different from a micro-economic model such as GMSIM. Again, due to budget constraints, Dr. Hsiao's proposal explicitly precluded a macro-economic analysis and instead relied on general qualitative estimates of possible effects. The Health Care Reform Commission was quite concerned about this omission.

To address this concern, we are requesting additional support for Dr. Hsiao to subcontract for the services of Thomas Kavet and Dr. Nicolas Rockler, principals at Kavet, Rockler & Associates, LLC (KRA), who have been Consulting Economists to the State Legislature for the past 15 years. KRA performs a wide range of economic analyses for the state legislature, including official economic and revenue forecasts which form the basis of the state's budgeting process, analyses of economic and revenue impacts associated with public policy and tax changes, and special studies on topics including prior healthcare initiatives, energy policy, education financing, economic development, agricultural policies, and detailed State demographic analyses. KRA has participated in the development of several state and regional economic models and maintains three macro-economic models for the Joint Fiscal Office for use in Vermont policy analysis. These include the REMI (Regional Economic Models, Inc.), REDYN (Regional Dynamics, Inc.) and IMPLAN models. The REMI model has been the most widely used for healthcare analysis, both in Vermont and elsewhere, and is the most likely source model to be employed in this analysis. KRA has used the REMI model in prior Vermont macro-economic forecasts of the state's health reform initiatives¹ and the impact of alternative financing mechanisms.

Dr. Hsiao would collaborate with Mr. Kavet and Dr. Rockler to select the appropriate model, ensure that it was calibrated consistently with Dr. Gruber's GMSIM and develop the appropriate specifications to test two of the proposed design options.

Products

The products would be two supplementary chapters that would be based on the proposed two modeling enhancements in the final report of the ACT 128 design project to the legislature. Dr Hsiao will have the primary responsibility for writing these two chapters.

¹ Kavet, T and Rockler, N, "Health Care Financing Analysis", Report prepared for Joint Fiscal Office, Vermont General Assembly, March 5, 2007

Project Management

Principle Investigator: William C Hsiao, PhD, FSA, K.T. Li Professor of Economics, Harvard University. Dr. Hsiao is a leading expert in health systems reform with decades of experience in the design and implementation of universal coverage.

Project Director: James A. Hester Jr., PhD, Director, Health Care Reform Commission, Vermont General Assembly. Dr. Hester has been one of the architects of the Vermont health reform initiatives for 9 years and has 35 years experience in designing, implementing and evaluating health care delivery systems.

Other key staff:

Jonathan Gruber, PhD, Professor of Economics, MIT. Dr. Gruber is one of the most prominent experts in designing state based universal coverage plans. He is an expert in the Affordable Care Act, served as an advisor to the Obama Administration and was one of the architects of the Massachusetts Health Connector.

Thomas E. Kavet, BA, President, Kavet, Rockler & Associates (KRA), an Economic and Public Policy Consultancy, offering professional services in the areas of: Economics, Public Policy Analysis, Demographics, Regional Economic Modeling and Information Systems. KRA has been the Consulting Economists to the Vermont State Legislature for the past 15 years.

Nicolas O Rockler, PhD, Chief Executive Officer, Kavet, Rockler & Associates (KRA), LLC, specializes in regional economics, regional econometric modeling, input/output economics, construction market economic analysis and forecasting, industry and regional economic impact analysis, demographic forecasting, state and local economic modeling and forecasting and state and local public finance.

Budget

The total support requested from the Commonwealth Fund is \$ 48,000. This would be supplemented by \$300,000 in Vermont general funds and \$1500 in kind contributions from the state. The detailed budget spreadsheet is shown in Attachment 2, but the main components of the requested support are as follows:

Baseline analysis using GMSIM (Gruber)	\$20,000
Macro-economic modeling (Kavet & Rockler)	\$20,000
Supervision and project mgt (Hsaio/Gosline)	\$8,000
Total	\$48,000

Attachments

1. Excerpt from Act 128
2. Budget Spreadsheet

3. Disclosure of other support: forms for Jim Hester, Bill Hsiao, Tom Kavet, Nic Rockler and Jonathan Gruber
4. Applicant information form
5. CV of Project Director, Jim Hester

Attachment 1: Excerpt from Act 128 - Sections 2, 3 and 6 (The complete text of Act 128 is available on the State of Vermont Legislature bill tracking system at <http://www.leg.state.vt.us/database/status/status.cfm>)

*** * * HEALTH CARE SYSTEM DESIGN * * ***

Sec. 2. PRINCIPLES FOR HEALTH CARE REFORM

The general assembly adopts the following principles as a framework for reforming health care in Vermont:

(1) It is the policy of the state of Vermont to ensure universal access to and coverage for essential health services for all Vermonters. All Vermonters must have access to comprehensive, quality health care. Systemic barriers must not prevent people from accessing necessary health care. All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting, and health care costs must be contained over time.

(2) The health care system must be transparent in design, efficient in operation, and accountable to the people it serves. The state must ensure public participation in the design, implementation, evaluation, and accountability mechanisms in the health care system.

(3) Primary care must be preserved and enhanced so that Vermonters have care available to them; preferably, within their own communities. Other aspects of Vermont's health care infrastructure must be supported in such a way that all Vermonters have access to necessary health services and that these health services are sustainable.

(4) Every Vermonter should be able to choose his or her primary care provider, as well as choosing providers of institutional and specialty care.

(5) The health care system will recognize the primacy of the patient-provider relationship, respecting the professional judgment of providers and the informed decisions of patients.

(6) Vermont's health delivery system must model continuous improvement of health care quality and safety and, therefore, the system must be evaluated for improvement in access, quality, and reliability and for a reduction in cost.

(7) A system for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs; reducing costs that do not contribute to efficient, quality health services; and reducing care that does not improve health outcomes, must be implemented for the health of the Vermont economy.

(8) The financing of health care in Vermont must be sufficient, fair, sustainable, and shared equitably.

(9) State government must ensure that the health care system satisfies the principles in this section.

Sec. 3. GOALS OF HEALTH CARE REFORM

Consistent with the adopted principles for reforming health care in Vermont, the general assembly adopts the following goals:

(1) The purpose of the health care system design proposals created by this act is to ensure that individual programs and initiatives can be placed into a larger, more rational design for access to, the delivery of, and the financing of affordable health care in Vermont.

(2) Vermont's primary care providers will be adequately compensated through a payment system that reduces administrative burdens on providers.

(3) Health care in Vermont will be organized and delivered in a patient-centered manner through community-based systems that:

- (A) are coordinated;
- (B) focus on meeting community health needs;
- (C) match service capacity to community needs;
- (D) provide information on costs, quality, outcomes, and patient satisfaction;
- (E) use financial incentives and organizational structure to achieve specific objectives;
- (F) improve continuously the quality of care provided; and
- (G) contain costs.

(4) To ensure financial sustainability of Vermont's health care system, the state is committed to slowing the rate of growth of total health care costs, preferably to reducing health care costs below today's amounts, and to raising revenues that are sufficient to support the state's financial obligations for health care on an ongoing basis.

(5) Health care costs will be controlled or reduced using a combination of options, including:

- (A) increasing the availability of primary care services throughout the state;
 - (B) simplifying reimbursement mechanisms throughout the health care system;
 - (C) reducing administrative costs associated with private and public insurance and bill collection;
 - (D) reducing the cost of pharmaceuticals, medical devices, and other supplies through a variety of mechanisms;
 - (E) aligning health care professional reimbursement with best practices and outcomes rather than utilization;
 - (F) efficient health facility planning, particularly with respect to technology;
- and
- (G) increasing price and quality transparency.

(6) All Vermont residents, subject to reasonable residency requirements, will have universal access to and coverage for health services that meet defined benefits standards, regardless of their age, employment, economic status, or town of residency, even if they require health care while outside Vermont.

(7) A system of health care will provide access to health services needed by individuals from birth to death and be responsive and seamless through employment and other life changes.

(8) A process will be developed to define packages of health services, taking into consideration scientific and research evidence, available funds, and the values and priorities of Vermonters, and analyzing required federal health benefit packages.

(9) Health care reform will ensure that Vermonters' health outcomes and key indicators of public health will show continuous improvement across all segments of the population.

(10) Health care reform will reduce the number of adverse events from medical errors.

(11) Disease and injury prevention, health promotion, and health protection will be key elements in the health care system.

...

Sec. 6. HEALTH CARE SYSTEM DESIGN AND IMPLEMENTATION PLAN

(a)(1)(A) By February 1, 2011, one or more consultants of the joint legislative commission on health care reform established in chapter 25 of Title 2 shall propose to the general assembly and the governor at least three design options, including implementation plans, for creating a single system of health care which ensures all Vermonters have access to and coverage for affordable, quality health services through a public or private single-payer or multipayer system and that meets the principles and goals outlined in Secs. 2 and 3 of this act. The proposal shall contain the analysis and recommendations as provided for in subsection (g) of this section.

(B) By January 1, 2011, the consultant shall release a draft of the design options to the public and provide 15 days for public review and the submission of comments on the design options. The consultant shall review and consider the public comments and revise the draft design options as necessary prior to the final submission to the general assembly and the governor.

(2)(A) One option shall design a government-administered and publicly financed "single-payer" health benefits system decoupled from employment which prohibits insurance coverage for the health services provided by this system and allows for private insurance coverage only of supplemental health services.

(B) One option shall design a public health benefit option administered by state government, which allows individuals to choose between the public option and private insurance coverage and allows for fair and robust competition among public and private plans.

(C) A third and any additional options shall be designed by the consultant, in consultation with the commission, taking into consideration the principles in Sec. 2 of this act, the goals in Sec. 3, and the parameters described in this section.

(3) Each design option shall include sufficient detail to allow the governor and the general assembly to consider the adoption of one design during the 2011 legislative session and to initiate implementation of the new system through a phased process beginning no later than July 1, 2012.

(b)(1) No later than 45 days after enactment, the commission shall propose to the joint fiscal committee a recommendation, including the requested amount, for one or more outside consultants who have demonstrated experience in designing health care systems that have expanded coverage and contained costs to provide the expertise necessary to do the analysis and design required by this act. Within seven days of the commission's proposal, the joint fiscal committee shall meet and may accept, reject, or modify the commission's proposal.

(2) The commission shall serve as a resource for the consultant by providing information and feedback to the consultant upon request, by recommending additional resources, and by receiving periodic progress reports by the consultant as needed. In order to maintain the independence of the consultant, the commission shall not direct the consultant's recommendations or proposal.

(c) In creating the designs, the consultant shall review and consider the following

fundamental elements:

(1) the findings and reports from previous studies of health care reform in Vermont, including the Universal Access Plan Report from the health care authority, November 1, 1993; reports from the Hogan Commission; relevant studies provided to the state of Vermont by the Lewin Group; and studies and reports provided to the commission.

(2) existing health care systems or components thereof in other states or countries as models.

(3) Vermont's current health care reform efforts as defined in 3 V.S.A. § 2222a.

(4) the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010; Employee Retirement Income Security Act (ERISA); and Titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act.

(d) Each design option shall propose a single system of health care which maximizes the federal funds to support the system and is composed of the following components, which are described in subsection (e) of this section:

(1) a payment system for health services which includes one or more packages of health services providing for the integration of physical and mental health; budgets, payment methods, and a process for determining payment amounts; and cost reduction and containment mechanisms;

(2) coordinated regional delivery systems;

(3) health system planning, regulation, and public health;

(4) financing and estimated costs, including federal financings; and

(5) a method to address compliance of the proposed design option or options with federal law.

(e) In creating the design options, the consultant shall include the following components for each option:

(1) A payment system for health services.

(A)(i) Packages of health services. In order to allow the general assembly a choice among varied packages of health services in each design option, the consultant shall provide at least two packages of health services providing for the integration of physical and mental health as further described in subdivision (A)(ii) of this subdivision (1) as part of each design option.

(ii)(I) Each design option shall include one package of health services which includes access to and coverage for primary care, preventive care, chronic care, acute episodic care, palliative care, hospice care, hospital services, prescription drugs, and mental health and substance abuse services.

(II) For each design option, the consultant shall consider including at least one additional package of health services, which includes the services described in subdivision (A)(ii)(I) of this subdivision (1) and coverage for supplemental health services, such as home- and community-based services, services in nursing homes, payment for transportation related to health services, or dental, hearing, or vision services.

(iii)(I) For each proposed package of health services, the consultant shall consider including a cost-sharing proposal that may provide a waiver of any deductible and other cost-sharing payments for chronic care for individuals participating in chronic

care management and for preventive care.

(II) For each proposed package of health services, the consultant shall consider including a proposal that has no cost-sharing. If this proposal is included, the consultant shall provide the cost differential between subdivision (A)(iii)(I) of this subdivision (1) and this subdivision (II).

(B) Administration. The consultant shall include a recommendation for:

(i) a method for administering payment for health services, which may include administration by a government agency, under an open bidding process soliciting bids from insurance carriers or third-party administrators, through private insurers, or a combination.

(ii) enrollment processes.

(iii) integration of the pharmacy best practices and cost control program established by 33 V.S.A. §§ 1996 and 1998 and other mechanisms to promote evidence-based prescribing, clinical efficacy, and cost-containment, such as a single statewide preferred drug list, prescriber education, or utilization reviews.

(iv) appeals processes for decisions made by entities or agencies administering coverage for health services.

(C) Budgets and payments. Each design shall include a recommendation for budgets, payment methods, and a process for determining payment amounts. Payment methods for mental health services shall be consistent with mental health parity. The consultant shall consider:

(i) amendments necessary to current law on the unified health care budget, including consideration of cost-containment mechanisms or targets, anticipated revenues available to support the expenditures, and other appropriate considerations, in order to establish a statewide spending target within which costs are controlled, resources directed, and quality and access assured.

(ii) how to align the unified health care budget with the health resource allocation plan under 18 V.S.A. § 9405; the hospital budget review process under 18 V.S.A. § 9456; and the proposed global budgets and payments, if applicable and recommended in a design option.

(iii) recommending a global budget where it is appropriate to ensure cost-containment by a health care facility, health care provider, a group of health care professionals, or a combination. Any recommendation shall include a process for developing a global budget, including circumstances under which an entity may seek an amendment of its budget, and any changes to the hospital budget process in 18 V.S.A. § 9456.

(iv) payment methods to be used for each health care sector which are aligned with the goals of this act and provide for cost-containment, provision of high quality, evidence-based health services in a coordinated setting, patient self-management, and healthy lifestyles. Payment methods may include:

(I) periodic payments based on approved annual global budgets;

(II) capitated payments;

(III) incentive payments to health care professionals based on performance standards, which may include evidence-based standard physiological measures, or if the health condition cannot be measured in that manner, a process measure, such as the appropriate frequency of testing or appropriate prescribing of

medications;

(IV) fee supplements if necessary to encourage specialized health care professionals to offer a specific, necessary health service which is not available in a specific geographic region;

(V) diagnosis-related groups;

(VI) global payments based on a global budget, including whether the global payment should be population-based, cover specific line items, provide a mixture of a lump sum payment, diagnosis-related group (DRG) payments, incentive payments for participation in the Blueprint for Health, quality improvements, or other health care reform initiatives as defined in 3 V.S.A. § 2222a; and

(VII) fee for service.

(v) what process or processes are appropriate for determining payment amounts with the intent to ensure reasonable payments to health care professionals and providers and to eliminate the shift of costs between the payers of health services by ensuring that the amount paid to health care professionals and providers is sufficient. Payment amounts should be in an amount which provides reasonable access to health services, provides sufficient uniform payment to health care professionals, and assists to create financial stability of health care professionals. Payment amounts shall be consistent with mental health parity. The consultant shall consider the following processes:

(I) Negotiations with hospitals, health care professionals, and groups of health care professionals;

(II) Establishing a global payment for health services provided by a particular hospital, health care provider, or group of professionals and providers. In recommending a process for determining a global payment, the consultant shall consider the interaction with a global budget and other information necessary to the determination of the appropriate payment, including all revenue received from other sources. The recommendation may include that the global payment be reflected as a specific line item in the annual budget.

(III) Negotiating a contract including payment methods and amounts with any out-of-state hospital or other health care provider that regularly treats a sufficient volume of Vermont residents, including contracting with out-of-state hospitals or health care providers for the provision of specialized health services that are not available locally to Vermonters.

(IV) Paying the amount charged for a medically necessary health service for which the individual received a referral or for an emergency health service customarily covered and received in an out-of-state hospital with which there is not an established contract;

(V) Developing a reference pricing system for nonemergency health services usually covered which are received in an out-of-state hospital or by a health care provider with which there is not a contract.

(VI) Utilizing one or more health care professional bargaining groups provided for in 18 V.S.A. § 9409, consisting of health care professionals who choose to participate and may propose criteria for forming and approving bargaining groups, and criteria and procedures for negotiations authorized by this section.

(D) Cost-containment. Each design shall include cost reduction and containment mechanisms. If the design option includes private insurers, the option may

include a fee assessed on insurers combined with a global budget to streamline administration of health services.

(2) Coordinated regional health systems. The consultant shall propose in each design a coordinated regional health system, which ensures that the delivery of health services to the citizens of Vermont is coordinated in order to improve health outcomes, improve the efficiency of the health system, and improve patients' experience of health services. The consultant shall review and analyze Vermont's existing efforts to reform the delivery of health care, including the Blueprint for Health described in chapter 13 of Title 18, and consider whether to build on or improve current reform efforts. In designing coordinated regional health systems, the consultant shall consider:

(A) how to ensure that health professionals, hospitals, health care facilities, and home- and community-based service providers offer health services in a coordinated manner designed to optimize health services at a lower cost, to reduce redundancies in the health system as a whole, and to improve quality;

(B) the creation of regional mechanisms to solicit public input for the regional health system; conduct a community needs assessment for incorporation into the health resources allocation plan; and plan for community health needs based on the community needs assessment; and

(C) the development of a regional entity, organization, or another mechanism to manage health services for that region's population, which may include making budget recommendations and resource allocations for the region; providing oversight and evaluation regarding the delivery of care in its region; developing payment methodologies and incentive payments; or other functions necessary to manage the region's health system.

(3) Health system planning, regulation, and public health. The consultant shall evaluate the existing mechanisms for health system and facility planning and for assessing quality indicators and outcomes and shall evaluate public health initiatives, including the health resource allocation plan, the certificate of need process, the Blueprint for Health, the statewide health information exchange, services provided by the Vermont Program for Quality in Health Care, and community prevention programs.

(4) Financing and estimated costs, including federal financing. The consultant shall provide:

(A) an estimate of the total costs of each design option, including any additional costs for providing access to and coverage for health services to the uninsured and underinsured; any estimated costs necessary to build a new system; and any estimated savings from implementing a single system.

(B) financing proposals for sustainable revenue, including by maximizing federal revenues, or reductions from existing health care programs, services, state agencies, or other sources necessary for funding the cost of the new system.

(C) a proposal to the Centers on Medicare and Medicaid Services to waive provisions of Titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act if necessary to align the federal programs with the proposals contained within the design options in order to maximize federal funds or to promote the simplification of administration, cost-containment, or promotion of health care reform initiatives as defined by 3 V.S.A. § 2222a.

(D) a proposal to participate in a federal insurance exchange established by the

Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 in order to maximize federal funds and, if applicable, a waiver from these provisions when available.

(5) A method to address compliance of the proposed design option or options with federal law if necessary, including the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010; Employee Retirement Income Security Act (ERISA); and Titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act. In the case of ERISA, the consultant may propose a strategy to seek an ERISA exemption from Congress if necessary for one of the design options.

(f)(1) The agency of human services and the department of banking, insurance, securities, and health care administration shall collaborate to ensure the commission and its consultant have the information necessary to create the design options.

(2) The consultant may request legal and fiscal assistance from the office of legislative council and the joint fiscal office.

(3) The commission or its consultant may engage with interested parties, such as health care providers and professionals, patient advocacy groups, and insurers, as necessary in order to have a full understanding of health care in Vermont.

(g) In the proposal and implementation plan provided to the general assembly and the governor as provided for in subsection (a) of this section, the consultant shall include:

(1) A recommendation for key indicators to measure and evaluate the design option chosen by the general assembly.

(2) An analysis of each design option, including:

(A) the financing and cost estimates outlined in subdivision (e)(4) of this section;

(B) the impacts on the current private and public insurance system;

(C) the expected net fiscal impact, including tax implications, on individuals and on businesses from the modifications to the health care system proposed in the design;

(D) impacts on the state's economy;

(E) the pros and cons of alternative timing for the implementation of each design, including the sequence and rationale for the phasing in of the major components; and

(F) the pros and cons of each design option and of no changes to the current system.

(3) A comparative analysis of the coverage, benefits, payments, health care delivery, and other features in each design option with Vermont's current health care system and health care reform efforts, the new federal insurance exchange, insurance regulatory provisions, and other provisions in the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010. The comparative analysis should be in a format to allow the general assembly to compare easily each design option with the current system and efforts. If appropriate, the analysis shall include a comparison of financial or other changes in Medicaid and Medicaid-funded programs in a format currently used by the department of Vermont health access in order to compare the estimates for the design option to the most current actual expenditures available.

(4) A recommendation for which of the design options best meets the principles and goals outlined in Secs. 2 and 3 of this act in an affordable, timely, and efficient manner. The recommendation section of the proposal shall not be finalized until after the receipt of public input as provided for in subdivision (a)(1)(B) of this section.

(h) After receipt of the proposal and implementation plan pursuant to subdivision (g)(2) of this section, the general assembly shall solicit input from interested members of the public and engage in a full and open public review and hearing process on the proposal and implementation plan.



STATE OF VERMONT
JOINT FISCAL OFFICE

MEMORANDUM

To: Joint Fiscal Committee Members
From: Nathan Lavery, Fiscal Analyst
Date: October 14, 2010
Subject: Grant Request

Enclosed please find three (3) requests that the Joint Fiscal Office has received from the administration.

JFO #2464 — \$365,000 grant from the U.S. Department of Justice to the Department of Corrections (DOC). These funds will allow DOC to develop and operate Circles of Support and Accountability (COSAs) for 24 high risk offenders reentering the community during the grant period.
[JFO received 10/07/10]

JFO #2465 — \$48,020 grant from the Commonwealth Fund to the Legislature – Health Care Reform Commission (HCRC). These funds will support health care design study by providing funding for the modeling of 1) the baseline scenario showing the impact of federal health care reform and 2) a macroeconomic impact of each design option on Vermont's economy. **Expedited review of this item has been request by HCRC. Joint Fiscal Committee members will be contacted by October 22 with a request to waive the statutory review period and accept this item.**
[JFO received 10/12/10]

JFO #2466 — \$25,000 grant from the U.S. Department of Agriculture to the Agency of Agriculture, Food and Markets. These funds will be used to develop a training program that can be used by owners and employees of slaughterhouses for purposes of helping to ensure that plant practices remain consistent with the Humane Methods of Slaughter Act and with state regulations.
[JFO received 10/14/10]

In accordance with the procedures for processing such requests, we ask you to review the enclosed and notify the Joint Fiscal Office (Nathan Lavery at 802-828-1488; nlavery@leg.state.vt.us) if you have questions or would like an item held for Joint Fiscal Committee review. Unless we hear from you to the contrary by October 29 we will assume that you agree to consider as final the Governor's acceptance of these requests.

cc: James Reardon, Commissioner
Andrew Pallito, Commissioner
James Hester, Director
Roger Allbee, Secretary



**STATE OF VERMONT
GENERAL ASSEMBLY**

REP. STEVEN MAIER
REP. MARK LARSON
REP. FRANCIS "TOPPER" McFAUN
REP. GEORGE W. TILL
SEN. JANE KITCHEL
SEN. VIRGINIA LYONS
SEN. ANN CUMMINGS
SEN. KEVIN MULLIN
JOHN BLOOMER
SHARON MOFFATT
CON HOGAN
JIM LEDDY

Health Care Reform Commission

MEMORANDUM

To: Joint Fiscal Committee Members
From: James Hester, Director, Health Care Reform Commission
Date: October 12, 2010
Subject: Commonwealth Fund Grant for Act 128 Study

Attached please find the materials related to the Commonwealth Fund grant to the Health Care Reform Commission. The grant will allow us to better meet the statutory expectations for the Health Care Study that is currently underway. We appreciate your support in approving acceptance of this grant.

Specifically the statute states the study is to include a baseline analysis and an analysis of each design option, including:

* * *

- (B) the impacts on the current private and public insurance system;
- (C) the expected net fiscal impact, including tax implications, on individuals and on businesses from the modifications to the health care system proposed in the design;
- (D) impacts on the state's economy;

Because of funding limitations, the proposal by Dr. Hsiao which was accepted and is the basis for the current study design and contract explicitly limited the baseline analysis and the impacts on the state economy to general qualitative analysis. The funding from the Commonwealth Fund grant would allow Dr. Hsiao to use economic modeling to significantly improve these analyses.

As noted in the attached grant materials, it is anticipated that certain amendments to the contract with Dr. Hsiao will be necessary to incorporate the enhanced work on the baseline economic analysis and various alternatives which are proposed.

The changes to the existing contract will need to be approved by signatories of the original contract through a formal amendment. The amendment will be developed with three specific parameters in mind: Consistency with the law and legislative intent surrounding the study; fulfilling the specific purposes of the grant as documented in the attached materials; and creating the flexibility for assessing changes which are likely to emerge from legislative deliberations. The legislative process is one where various options are explored. We are interested in structuring the economic analysis in a way that increases the capacity to assess the economic impacts of various proposals and modifications as the legislative process unfolds.

State of Vermont
 Department of Finance & Management
 109 State Street, Pavilion Building
 Montpelier, VT 05620-0401

[phone] 802-828-2376
 [fax] 802-828-2428

Agency of Administration

STATE OF VERMONT
FINANCE & MANAGEMENT GRANT REVIEW FORM

Grant Summary:		Commonwealth Fund support for design and evaluation of health care reform.			
Date:		10/06/2010			
Department:		Legislature - Health Care Reform Commission			
Legal Title of Grant:		Enhanced Modeling of Baseline Federal Reform & Impact on Vermont Economy			
Federal Catalog #:		NA			
Grant/Donor Name and Address:		Commonwealth Fund, Washington, D.C.			
Grant Period:	From:	10/1/2010	To:	2/1/2011	
Grant/Donation		\$48,000			
	SFY 1	SFY 2	SFY 3	Total	Comments
Grant Amount:	\$48,020	\$	\$	\$48,020	
Position Information:	# Positions	Explanation/Comments			
	0				
Additional Comments:		Funding enables enhanced modeling.			
Department of Finance & Management		10/6/10	(Initial) DB		
Secretary of Administration		TP 10/6/10	(Initial) 10-6-10		
Sent To Joint Fiscal Office			Date		



STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

BASIC GRANT INFORMATION

1. Agency:	Vermont State Legislature		
2. Department:	Health Care Reform Commission		
3. Program:			
4. Legal Title of Grant:	Enhanced Modeling of Baseline Federal Reform and Impact on Vermont Economy		
5. Federal Catalog #:			
6. Grant/Donor Name and Address:	The Commonwealth Fund, 1150 17th St. NW, Suite 600 Washington, DC 20036		
7. Grant Period:	From:	10/1/2010	To: 2/1/2011
8. Purpose of Grant:	Fulfill requirement of Act 128 of 2010 (Section 6) to design and evaluate three health reform options. Act 128 directed the HCRC to seek additional grant funding to support enhanced modeling work in the analysis. This grant provides the support for modeling of 1) the baseline scenario showing the impact of the Federal Affordable Care Act and 2) macro-economic impact of health reform on the state's economy.		
9. Impact on existing program if grant is not Accepted:	Enhanced modeling will not be done.		

10. BUDGET INFORMATION

	SFY 1	SFY 2	SFY 3	Comments
Expenditures:	FY 2011	FY	FY	
Personal Services	\$48,020	\$	\$	
Operating Expenses	\$	\$	\$	
Grants	\$	\$	\$	
Total	\$48,020	\$	\$	
Revenues:				
State Funds:	\$	\$	\$	
Cash	\$	\$	\$	
In-Kind	\$	\$	\$	
Federal Funds:	\$	\$	\$	
(Direct Costs)	\$	\$	\$	
(Statewide Indirect)	\$	\$	\$	
(Departmental Indirect)	\$	\$	\$	
Other Funds:	\$	\$	\$	
Grant (source)	\$48,020	\$	\$	
Total	\$48,020	\$	\$	

Appropriation No:	1210002000	Amount:	\$48,020
			\$
			\$
			\$
			\$

STATE OF VERMONT REQUEST FOR GRANT ACCEPTANCE (Form AA-1)

		\$
		\$
		\$
	Total	\$ 48,020

PERSONAL SERVICE INFORMATION

11. Will monies from this grant be used to fund one or more Personal Service Contracts? Yes No
 If "Yes", appointing authority must initial here to indicate intent to follow current competitive bidding process/policy.
 Appointing Authority Name: Jim Hester Agreed by: JAH (initial)

12. Limited Service Position Information:	# Positions	Title
Total Positions		

12a. Equipment and space for these positions: Is presently available. Can be obtained with available funds.

13. AUTHORIZATION AGENCY/DEPARTMENT

I/we certify that no funds beyond basic application preparation and filing costs have been expended or committed in anticipation of Joint Fiscal Committee approval of this grant, unless previous notification was made on Form AA-1PN (if applicable):

Signature: <u>[Signature]</u>	Date: 9/30/2010
Title: Director, Health Care Reform Commission	
Signature: <u>[Signature]</u>	Date: <u> </u>
Title: <u> </u>	

14. SECRETARY OF ADMINISTRATION

Approved: (Secretary or designee signature) [Signature] Date: 10/6/10

15. ACTION BY GOVERNOR

Check One Box: Accepted (Governor's signature) [Signature] Date: 10/7/10

Rejected

16. DOCUMENTATION REQUIRED

Required GRANT Documentation

<input checked="" type="checkbox"/> Request Memo	<input type="checkbox"/> Notice of Donation (if any)
<input type="checkbox"/> Dept. project approval (if applicable)	<input checked="" type="checkbox"/> Grant (Project) Timeline (if applicable)
<input checked="" type="checkbox"/> Notice of Award	<input type="checkbox"/> Request for Extension (if applicable)
<input type="checkbox"/> Grant Agreement	<input type="checkbox"/> Form AA-1PN attached (if applicable)
<input type="checkbox"/> Grant Budget	

End Form AA-1

Beatty, David

From: Nathan Lavery [nlavery@leg.state.vt.us]
Sent: Wednesday, October 06, 2010 11:03 AM
To: Beatty, David
Subject: Small grant proposal for enhanced modeling

In fact, you were copied on this email. Commonwealth apparently doesn't provide an "Award Letter" in the way we typically encounter them. So this email should be considered confirmation of the award.

>>> "Heather Drake" <HD@CMWF.org> 10/5/2010 4:22 PM >>>
Hi Jim:

We just received word the your proposal has been given final approval by the Chair of our Board.

We will get you the Letter of Agreement and Payment and Reporting Schedule to you as soon as we can.

Thank you,
Heather

-----Original Message-----

From: Jim Hester [mailto:jhester@leg.state.vt.us]
Sent: Tuesday, October 05, 2010 2:02 PM
To: Stuart Guterman
Cc: Heather Drake; Nathan Lavery; David Beatty
Subject: RE: Small grant proposal for enhanced modeling

Stu/Heather,
Could I get some form of confirmation (e mail is fine) that the final sign off has occurred? We are processing the internal paperwork to accept the grant and can't proceed until we have this confirmation.
Thanks.

Jim

Jim Hester PhD
Director
Health Care Reform Commission
14-16 Baldwin St
Montpelier VT 05633
802 828-1107 (o)
802 734-1649 (cell)
jhester@leg.state.vt.us

>>> "Stuart Guterman" <SXG@CMWF.org> 9/27/2010 9:51 PM >>>
Hi, Jim--

We had our small grants review meeting this afternoon, and I'm glad to report that the staff decided to go ahead with your project. The

MEMORANDUM

To: Rep. Michael Obuchowski, Chair, Joint Fiscal Committee
James Reardon, Commissioner of Finance & Management

From: James Hester, Director, Health Care Reform Commission

Date: September 30, 2010

Subject: Expedited review request

JAH

The Health Care Reform Commission (HCRC) respectfully requests that Finance and Management and the Joint Fiscal Committee expedite their respective reviews of the grant from the Commonwealth Fund for Enhanced Modeling of Baseline Federal Reform and Impact on the Vermont Economy.

HCRC was notified of this award on September 27, 2010. Expedite review is necessary because the grant period is short and begins on October 1, 2010, with the initial payment from the foundation due 10/15.. Below is a timeline of activities that reflect the condensed nature of this project, including the expectation that work will begin in early November.

10/5/2010	Executed Letter of Agreement
10/15/2010	Check for \$38,416
10/22/2010	Draft subcontracts with Thomas Kavet and Dr. Nicolas Rockler
11/5/2010	Executed subcontracts with Thomas Kavet and Dr. Nicolas Rockler
11/30/2010	Update on modeling of baseline case and macroeconomic modeling
12/31/2010	Draft supplementary chapters on modeling enhancements
2/1/2011	Final supplementary chapters on modeling enhancements
3/1/2011	Final financial report for period (10/1/10-2/1/11)
3/15/2011	Check for \$9,604, dependent upon actual expenses

Design of Three Options for Statewide Health Care Reform in Vermont:
Proposal for
Enhanced Modeling of Baseline Federal Reform and Impact on Vermont Economy
Project Director: James Hester Jr. Ph.D.
Health Care Reform Commission, Vermont General Assembly
Proposed Grant Amount: \$48,000
Project Period: 10/1/2010 to 2/1/2011

Background

Since 2006, Vermont has been implementing a comprehensive set of health care reform initiatives with the goals of reducing the number of uninsured residents in the state, accelerating the implementation of health information technology and transforming the health care delivery system to improve its performance and slow the rate of increase in medical costs. Act 191, the original health reform legislation passed in 2006, has been enhanced each year with additional legislation which built on existing efforts and added new programs. In the last eighteen months the Health Care Reform Commission, other legislative staff and standing health policy committees of the House and Senate have had the additional task of following the Federal health reform debate, attempting to share the lessons learned in Vermont and assessing how the new Federal health legislation, the Affordable Care Act or ACA, will affect Vermont. As a result of this work at both the Federal and state level, in its 2010 session the Vermont General Assembly passed Act 128, the latest link in the five year chain of state legislation.

Act 128 continued the process of incremental state initiatives and acknowledged the Federal efforts, but concluded that a more fundamental review of health care reform options was needed to create the framework for long term reform. It spelled out the goals and principles of meaningful health care reform and funded a major effort to design three alternative large scale health system options for Vermont (Attachment 1). One option is based on the single payer model, one is based on a public option, and the third is designed by the consultants. The intent is to create a larger scale state framework which integrates the planned Vermont and federal reforms and provides a working design for a more complete health system reform. In particular, the designs will include sufficient detail to move beyond the rhetoric which has dominated the health reform debate and provide the legislature with specific information to inform its debate about how to move Vermont forward from its current state.

Act 128 requires that each of the three design options is quite comprehensive in scope and should include

- (1) a payment system for health services which includes one or more packages of health services providing for the integration of physical and mental health; budgets, payment methods, and a process for determining payment amounts; and cost reduction and containment mechanisms;
- (2) coordinated regional delivery systems;

- (3) health system planning, regulation, and public health;
- (4) financing and estimated costs, including federal financings; and
- (5) a method to address compliance of the proposed design option or options with federal law.

The schedule for this project is quite aggressive. The draft report with three designs is due 1/1/11 and the final report is due 2/1/11 so that the legislature can consider them next session. The commission administered a competitive RFP process and selected a team led by Professor William Hsiao of Harvard to do the designs. His proposal addressed each of the five components of the design using a combination of economic modeling, stakeholder interviews and analysis, and staff analysis. Act 128 provided \$300,000 in state general funds to support the project.

Project Description

Act 128 encouraged the Health Care Reform Commission to seek external grant support to build on the state funded work plan. After consulting with Commonwealth Fund staff, we are submitting this proposal for a small grant to strengthen the economic modeling for the design.

Act 128 requires an estimate of the total costs, the costs to Vermont state government and the distributional impacts of each of the three design options. Dr Hsiao proposed to subcontract with Dr. Jonathan Gruber of MIT to use the Gruber Microsimulation Model (GMSIM) for this analysis. Dr. Gruber has developed this model over the last decade and it has been widely used to estimate the impact of health reforms on costs and insurance coverage at both the national and state levels. Since Vermont has state level data from its own health insurance surveys (Vermont Household Health Insurance Survey), Dr. Gruber will recalibrate the GMSIM using this more detailed information instead of state estimates from the Current Population Survey. In addition he will have access to the state wide all payer claims data base (VHCURES) which currently has complete data for 2007 and 2008, as well as the annual expenditure analysis which tracks total health care expenses within and outside the state for all residents. The state funding will support this work and the analysis of the three design options

We are requesting support for two enhancements to the planned economic modeling. Dr Hsiao would be the Principle Investigator for the enhancements and ensure that they were coordinated with each other and integrated effectively into the overall design. Dr. Hester as Project Director would amend the existing contract between the Health Care Reform Commission and Dr. Hsiao to include these two enhancements.

- 1) **Enhanced modeling of baseline case:** The impacts of the three proposed design options will be compared to a baseline case which continues the existing Vermont health reform initiatives and phases in the Federal health care reforms in the Affordable Care Act (ACA). Because of funding limitations, the Dr. Hsiao was not able to use the GMSIM for this analysis of the baseline case and instead planned to make subjective estimates using state and national experts. We believe that the analysis would be greatly enhanced by expanding Dr. Hsiao's subcontract

to Dr. Gruber to add a fourth, baseline case to the GMSIM simulations so that we could have a more accurate estimate of the state's starting point. In addition, this baseline analysis would be extremely valuable to the state agencies which are planning for the implementation of ACA and need to estimate its effect on total costs, the state's share of those costs, insurance coverage and distributional impacts. Approximately 150,000 residents, or 23% of the state's population, are currently enrolled in state funded health insurance programs and ACA should have a significant impact on both enrollment and the state's costs.

- 2) **Macroeconomic modeling:** One of the major concerns about the impact of health care reform and changes in the financing of health care coverage is the potential impact on the state's economy. Assessing these impacts requires a macro-economic model of the economy which is completely different from a micro-economic model such as GMSIM. Again, due to budget constraints, Dr. Hsiao's proposal explicitly precluded a macro-economic analysis and instead relied on general qualitative estimates of possible effects. The Health Care Reform Commission was quite concerned about this omission.

To address this concern, we are requesting additional support for Dr. Hsiao to subcontract for the services of Thomas Kavet and Dr. Nicolas Rockler, principals at Kavet, Rockler & Associates, LLC (KRA), who have been Consulting Economists to the State Legislature for the past 15 years. KRA performs a wide range of economic analyses for the state legislature, including official economic and revenue forecasts which form the basis of the state's budgeting process, analyses of economic and revenue impacts associated with public policy and tax changes, and special studies on topics including prior healthcare initiatives, energy policy, education financing, economic development, agricultural policies, and detailed State demographic analyses. KRA has participated in the development of several state and regional economic models and maintains three macro-economic models for the Joint Fiscal Office for use in Vermont policy analysis. These include the REMI (Regional Economic Models, Inc.), REDYN (Regional Dynamics, Inc.) and IMPLAN models. The REMI model has been the most widely used for healthcare analysis, both in Vermont and elsewhere, and is the most likely source model to be employed in this analysis. KRA has used the REMI model in prior Vermont macro-economic forecasts of the state's health reform initiatives¹ and the impact of alternative financing mechanisms.

Dr. Hsiao would collaborate with Mr. Kavet and Dr. Rockler to select the appropriate model, ensure that it was calibrated consistently with Dr. Gruber's GMSIM and develop the appropriate specifications to test two of the proposed design options.

Products

The products would be two supplementary chapters that would be based on the proposed two modeling enhancements in the final report of the ACT 128 design project to the legislature. Dr Hsiao will have the primary responsibility for writing these two chapters.

¹ Kavet, T and Rockler, N, "Health Care Financing Analysis", Report prepared for Joint Fiscal Office, Vermont General Assembly, March 5, 2007

Project Management

Principle Investigator: William C Hsiao, PhD, FSA, K.T. Li Professor of Economics, Harvard University. Dr. Hsiao is a leading expert in health systems reform with decades of experience in the design and implementation of universal coverage.

Project Director: James A. Hester Jr., PhD, Director, Health Care Reform Commission, Vermont General Assembly. Dr. Hester has been one of the architects of the Vermont health reform initiatives for 9 years and has 35 years experience in designing, implementing and evaluating health care delivery systems.

Other key staff:

Jonathan Gruber, PhD, Professor of Economics, MIT. Dr. Gruber is one of the most prominent experts in designing state based universal coverage plans. He is an expert in the Affordable Care Act, served as an advisor to the Obama Administration and was one of the architects of the Massachusetts Health Connector.

Thomas E. Kavet, BA, President, Kavet, Rockler & Associates (KRA), an Economic and Public Policy Consultancy, offering professional services in the areas of: Economics, Public Policy Analysis, Demographics, Regional Economic Modeling and Information Systems. KRA has been the Consulting Economists to the Vermont State Legislature for the past 15 years.

Nicolas O Rockler, PhD, Chief Executive Officer, Kavet, Rockler & Associates (KRA), LLC, specializes in regional economics, regional econometric modeling, input/output economics, construction market economic analysis and forecasting, industry and regional economic impact analysis, demographic forecasting, state and local economic modeling and forecasting and state and local public finance.

Budget

The total support requested from the Commonwealth Fund is \$ 48,000. This would be supplemented by \$300,000 in Vermont general funds and \$1500 in kind contributions from the state. The detailed budget spreadsheet is shown in Attachment 2, but the main components of the requested support are as follows:

Baseline analysis using GMSIM (Gruber)	\$20,000
Macro-economic modeling (Kavet & Rockler)	\$20,000
Supervision and project mgt (Hsaio/Gosline)	\$8,000
Total	\$48,000

Attachments

1. Excerpt from Act 128
2. Budget Spreadsheet

3. Disclosure of other support: forms for Jim Hester, Bill Hsiao, Tom Kavet, Nic Rockler and Jonathan Gruber
4. Applicant information form
5. CV of Project Director, Jim Hester

Attachment 1: Excerpt from Act 128 - Sections 2, 3 and 6 (The complete text of Act 128 is available on the State of Vermont Legislature bill tracking system at <http://www.leg.state.vt.us/database/status/status.cfm>)

*** * * HEALTH CARE SYSTEM DESIGN * * ***

Sec. 2. PRINCIPLES FOR HEALTH CARE REFORM

The general assembly adopts the following principles as a framework for reforming health care in Vermont:

(1) It is the policy of the state of Vermont to ensure universal access to and coverage for essential health services for all Vermonters. All Vermonters must have access to comprehensive, quality health care. Systemic barriers must not prevent people from accessing necessary health care. All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting, and health care costs must be contained over time.

(2) The health care system must be transparent in design, efficient in operation, and accountable to the people it serves. The state must ensure public participation in the design, implementation, evaluation, and accountability mechanisms in the health care system.

(3) Primary care must be preserved and enhanced so that Vermonters have care available to them; preferably, within their own communities. Other aspects of Vermont's health care infrastructure must be supported in such a way that all Vermonters have access to necessary health services and that these health services are sustainable.

(4) Every Vermonter should be able to choose his or her primary care provider, as well as choosing providers of institutional and specialty care.

(5) The health care system will recognize the primacy of the patient-provider relationship, respecting the professional judgment of providers and the informed decisions of patients.

(6) Vermont's health delivery system must model continuous improvement of health care quality and safety and, therefore, the system must be evaluated for improvement in access, quality, and reliability and for a reduction in cost.

(7) A system for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs; reducing costs that do not contribute to efficient, quality health services; and reducing care that does not improve health outcomes, must be implemented for the health of the Vermont economy.

(8) The financing of health care in Vermont must be sufficient, fair, sustainable, and shared equitably.

(9) State government must ensure that the health care system satisfies the principles in this section.

Sec. 3. GOALS OF HEALTH CARE REFORM

Consistent with the adopted principles for reforming health care in Vermont, the general assembly adopts the following goals:

(1) The purpose of the health care system design proposals created by this act is to ensure that individual programs and initiatives can be placed into a larger, more rational design for access to, the delivery of, and the financing of affordable health care in Vermont.

(2) Vermont's primary care providers will be adequately compensated through a payment system that reduces administrative burdens on providers.

(3) Health care in Vermont will be organized and delivered in a patient-centered manner through community-based systems that:

- (A) are coordinated;
- (B) focus on meeting community health needs;
- (C) match service capacity to community needs;
- (D) provide information on costs, quality, outcomes, and patient satisfaction;
- (E) use financial incentives and organizational structure to achieve specific objectives;
- (F) improve continuously the quality of care provided; and
- (G) contain costs.

(4) To ensure financial sustainability of Vermont's health care system, the state is committed to slowing the rate of growth of total health care costs, preferably to reducing health care costs below today's amounts, and to raising revenues that are sufficient to support the state's financial obligations for health care on an ongoing basis.

(5) Health care costs will be controlled or reduced using a combination of options, including:

- (A) increasing the availability of primary care services throughout the state;
 - (B) simplifying reimbursement mechanisms throughout the health care system;
 - (C) reducing administrative costs associated with private and public insurance and bill collection;
 - (D) reducing the cost of pharmaceuticals, medical devices, and other supplies through a variety of mechanisms;
 - (E) aligning health care professional reimbursement with best practices and outcomes rather than utilization;
 - (F) efficient health facility planning, particularly with respect to technology;
- and
- (G) increasing price and quality transparency.

(6) All Vermont residents, subject to reasonable residency requirements, will have universal access to and coverage for health services that meet defined benefits standards, regardless of their age, employment, economic status, or town of residency, even if they require health care while outside Vermont.

(7) A system of health care will provide access to health services needed by individuals from birth to death and be responsive and seamless through employment and other life changes.

(8) A process will be developed to define packages of health services, taking into consideration scientific and research evidence, available funds, and the values and priorities of Vermonters, and analyzing required federal health benefit packages.

(9) Health care reform will ensure that Vermonters' health outcomes and key indicators of public health will show continuous improvement across all segments of the population.

(10) Health care reform will reduce the number of adverse events from medical errors.

(11) Disease and injury prevention, health promotion, and health protection will be key elements in the health care system.

...

Sec. 6. HEALTH CARE SYSTEM DESIGN AND IMPLEMENTATION PLAN

(a)(1)(A) By February 1, 2011, one or more consultants of the joint legislative commission on health care reform established in chapter 25 of Title 2 shall propose to the general assembly and the governor at least three design options, including implementation plans, for creating a single system of health care which ensures all Vermonters have access to and coverage for affordable, quality health services through a public or private single-payer or multipayer system and that meets the principles and goals outlined in Secs. 2 and 3 of this act. The proposal shall contain the analysis and recommendations as provided for in subsection (g) of this section.

(B) By January 1, 2011, the consultant shall release a draft of the design options to the public and provide 15 days for public review and the submission of comments on the design options. The consultant shall review and consider the public comments and revise the draft design options as necessary prior to the final submission to the general assembly and the governor.

(2)(A) One option shall design a government-administered and publicly financed "single-payer" health benefits system decoupled from employment which prohibits insurance coverage for the health services provided by this system and allows for private insurance coverage only of supplemental health services.

(B) One option shall design a public health benefit option administered by state government, which allows individuals to choose between the public option and private insurance coverage and allows for fair and robust competition among public and private plans.

(C) A third and any additional options shall be designed by the consultant, in consultation with the commission, taking into consideration the principles in Sec. 2 of this act, the goals in Sec. 3, and the parameters described in this section.

(3) Each design option shall include sufficient detail to allow the governor and the general assembly to consider the adoption of one design during the 2011 legislative session and to initiate implementation of the new system through a phased process beginning no later than July 1, 2012.

(b)(1) No later than 45 days after enactment, the commission shall propose to the joint fiscal committee a recommendation, including the requested amount, for one or more outside consultants who have demonstrated experience in designing health care systems that have expanded coverage and contained costs to provide the expertise necessary to do the analysis and design required by this act. Within seven days of the commission's proposal, the joint fiscal committee shall meet and may accept, reject, or modify the commission's proposal.

(2) The commission shall serve as a resource for the consultant by providing information and feedback to the consultant upon request, by recommending additional resources, and by receiving periodic progress reports by the consultant as needed. In order to maintain the independence of the consultant, the commission shall not direct the consultant's recommendations or proposal.

(c) In creating the designs, the consultant shall review and consider the following

fundamental elements:

(1) the findings and reports from previous studies of health care reform in Vermont, including the Universal Access Plan Report from the health care authority, November 1, 1993; reports from the Hogan Commission; relevant studies provided to the state of Vermont by the Lewin Group; and studies and reports provided to the commission.

(2) existing health care systems or components thereof in other states or countries as models.

(3) Vermont's current health care reform efforts as defined in 3 V.S.A. § 2222a.

(4) the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010; Employee Retirement Income Security Act (ERISA); and Titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act.

(d) Each design option shall propose a single system of health care which maximizes the federal funds to support the system and is composed of the following components, which are described in subsection (e) of this section:

(1) a payment system for health services which includes one or more packages of health services providing for the integration of physical and mental health; budgets, payment methods, and a process for determining payment amounts; and cost reduction and containment mechanisms;

(2) coordinated regional delivery systems;

(3) health system planning, regulation, and public health;

(4) financing and estimated costs, including federal financings; and

(5) a method to address compliance of the proposed design option or options with federal law.

(e) In creating the design options, the consultant shall include the following components for each option:

(1) A payment system for health services.

(A)(i) Packages of health services. In order to allow the general assembly a choice among varied packages of health services in each design option, the consultant shall provide at least two packages of health services providing for the integration of physical and mental health as further described in subdivision (A)(ii) of this subdivision (1) as part of each design option.

(ii)(I) Each design option shall include one package of health services which includes access to and coverage for primary care, preventive care, chronic care, acute episodic care, palliative care, hospice care, hospital services, prescription drugs, and mental health and substance abuse services.

(II) For each design option, the consultant shall consider including at least one additional package of health services, which includes the services described in subdivision (A)(ii)(I) of this subdivision (1) and coverage for supplemental health services, such as home- and community-based services, services in nursing homes, payment for transportation related to health services, or dental, hearing, or vision services.

(iii)(I) For each proposed package of health services, the consultant shall consider including a cost-sharing proposal that may provide a waiver of any deductible and other cost-sharing payments for chronic care for individuals participating in chronic

care management and for preventive care.

(II) For each proposed package of health services, the consultant shall consider including a proposal that has no cost-sharing. If this proposal is included, the consultant shall provide the cost differential between subdivision (A)(iii)(I) of this subdivision (1) and this subdivision (II).

(B) Administration. The consultant shall include a recommendation for:

(i) a method for administering payment for health services, which may include administration by a government agency, under an open bidding process soliciting bids from insurance carriers or third-party administrators, through private insurers, or a combination.

(ii) enrollment processes.

(iii) integration of the pharmacy best practices and cost control program established by 33 V.S.A. §§ 1996 and 1998 and other mechanisms to promote evidence-based prescribing, clinical efficacy, and cost-containment, such as a single statewide preferred drug list, prescriber education, or utilization reviews.

(iv) appeals processes for decisions made by entities or agencies administering coverage for health services.

(C) Budgets and payments. Each design shall include a recommendation for budgets, payment methods, and a process for determining payment amounts. Payment methods for mental health services shall be consistent with mental health parity. The consultant shall consider:

(i) amendments necessary to current law on the unified health care budget, including consideration of cost-containment mechanisms or targets, anticipated revenues available to support the expenditures, and other appropriate considerations, in order to establish a statewide spending target within which costs are controlled, resources directed, and quality and access assured.

(ii) how to align the unified health care budget with the health resource allocation plan under 18 V.S.A. § 9405; the hospital budget review process under 18 V.S.A. § 9456; and the proposed global budgets and payments, if applicable and recommended in a design option.

(iii) recommending a global budget where it is appropriate to ensure cost-containment by a health care facility, health care provider, a group of health care professionals, or a combination. Any recommendation shall include a process for developing a global budget, including circumstances under which an entity may seek an amendment of its budget, and any changes to the hospital budget process in 18 V.S.A. § 9456.

(iv) payment methods to be used for each health care sector which are aligned with the goals of this act and provide for cost-containment, provision of high quality, evidence-based health services in a coordinated setting, patient self-management, and healthy lifestyles. Payment methods may include:

(I) periodic payments based on approved annual global budgets;

(II) capitated payments;

(III) incentive payments to health care professionals based on performance standards, which may include evidence-based standard physiological measures, or if the health condition cannot be measured in that manner, a process measure, such as the appropriate frequency of testing or appropriate prescribing of

medications;

(IV) fee supplements if necessary to encourage specialized health care professionals to offer a specific, necessary health service which is not available in a specific geographic region;

(V) diagnosis-related groups;

(VI) global payments based on a global budget, including whether the global payment should be population-based, cover specific line items, provide a mixture of a lump sum payment, diagnosis-related group (DRG) payments, incentive payments for participation in the Blueprint for Health, quality improvements, or other health care reform initiatives as defined in 3 V.S.A. § 2222a; and

(VII) fee for service.

(v) what process or processes are appropriate for determining payment amounts with the intent to ensure reasonable payments to health care professionals and providers and to eliminate the shift of costs between the payers of health services by ensuring that the amount paid to health care professionals and providers is sufficient. Payment amounts should be in an amount which provides reasonable access to health services, provides sufficient uniform payment to health care professionals, and assists to create financial stability of health care professionals. Payment amounts shall be consistent with mental health parity. The consultant shall consider the following processes:

(I) Negotiations with hospitals, health care professionals, and groups of health care professionals;

(II) Establishing a global payment for health services provided by a particular hospital, health care provider, or group of professionals and providers. In recommending a process for determining a global payment, the consultant shall consider the interaction with a global budget and other information necessary to the determination of the appropriate payment, including all revenue received from other sources. The recommendation may include that the global payment be reflected as a specific line item in the annual budget.

(III) Negotiating a contract including payment methods and amounts with any out-of-state hospital or other health care provider that regularly treats a sufficient volume of Vermont residents, including contracting with out-of-state hospitals or health care providers for the provision of specialized health services that are not available locally to Vermonters.

(IV) Paying the amount charged for a medically necessary health service for which the individual received a referral or for an emergency health service customarily covered and received in an out-of-state hospital with which there is not an established contract;

(V) Developing a reference pricing system for nonemergency health services usually covered which are received in an out-of-state hospital or by a health care provider with which there is not a contract.

(VI) Utilizing one or more health care professional bargaining groups provided for in 18 V.S.A. § 9409, consisting of health care professionals who choose to participate and may propose criteria for forming and approving bargaining groups, and criteria and procedures for negotiations authorized by this section.

(D) Cost-containment. Each design shall include cost reduction and containment mechanisms. If the design option includes private insurers, the option may

include a fee assessed on insurers combined with a global budget to streamline administration of health services.

(2) Coordinated regional health systems. The consultant shall propose in each design a coordinated regional health system, which ensures that the delivery of health services to the citizens of Vermont is coordinated in order to improve health outcomes, improve the efficiency of the health system, and improve patients' experience of health services. The consultant shall review and analyze Vermont's existing efforts to reform the delivery of health care, including the Blueprint for Health described in chapter 13 of Title 18, and consider whether to build on or improve current reform efforts. In designing coordinated regional health systems, the consultant shall consider:

(A) how to ensure that health professionals, hospitals, health care facilities, and home- and community-based service providers offer health services in a coordinated manner designed to optimize health services at a lower cost, to reduce redundancies in the health system as a whole, and to improve quality;

(B) the creation of regional mechanisms to solicit public input for the regional health system; conduct a community needs assessment for incorporation into the health resources allocation plan; and plan for community health needs based on the community needs assessment; and

(C) the development of a regional entity, organization, or another mechanism to manage health services for that region's population, which may include making budget recommendations and resource allocations for the region; providing oversight and evaluation regarding the delivery of care in its region; developing payment methodologies and incentive payments; or other functions necessary to manage the region's health system.

(3) Health system planning, regulation, and public health. The consultant shall evaluate the existing mechanisms for health system and facility planning and for assessing quality indicators and outcomes and shall evaluate public health initiatives, including the health resource allocation plan, the certificate of need process, the Blueprint for Health, the statewide health information exchange, services provided by the Vermont Program for Quality in Health Care, and community prevention programs.

(4) Financing and estimated costs, including federal financing. The consultant shall provide:

(A) an estimate of the total costs of each design option, including any additional costs for providing access to and coverage for health services to the uninsured and underinsured; any estimated costs necessary to build a new system; and any estimated savings from implementing a single system.

(B) financing proposals for sustainable revenue, including by maximizing federal revenues, or reductions from existing health care programs, services, state agencies, or other sources necessary for funding the cost of the new system.

(C) a proposal to the Centers on Medicare and Medicaid Services to waive provisions of Titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act if necessary to align the federal programs with the proposals contained within the design options in order to maximize federal funds or to promote the simplification of administration, cost-containment, or promotion of health care reform initiatives as defined by 3 V.S.A. § 2222a.

(D) a proposal to participate in a federal insurance exchange established by the

Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 in order to maximize federal funds and, if applicable, a waiver from these provisions when available.

(5) A method to address compliance of the proposed design option or options with federal law if necessary, including the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010; Employee Retirement Income Security Act (ERISA); and Titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act. In the case of ERISA, the consultant may propose a strategy to seek an ERISA exemption from Congress if necessary for one of the design options.

(f)(1) The agency of human services and the department of banking, insurance, securities, and health care administration shall collaborate to ensure the commission and its consultant have the information necessary to create the design options.

(2) The consultant may request legal and fiscal assistance from the office of legislative council and the joint fiscal office.

(3) The commission or its consultant may engage with interested parties, such as health care providers and professionals, patient advocacy groups, and insurers, as necessary in order to have a full understanding of health care in Vermont.

(g) In the proposal and implementation plan provided to the general assembly and the governor as provided for in subsection (a) of this section, the consultant shall include:

(1) A recommendation for key indicators to measure and evaluate the design option chosen by the general assembly.

(2) An analysis of each design option, including:

(A) the financing and cost estimates outlined in subdivision (e)(4) of this section;

(B) the impacts on the current private and public insurance system;

(C) the expected net fiscal impact, including tax implications, on individuals and on businesses from the modifications to the health care system proposed in the design;

(D) impacts on the state's economy;

(E) the pros and cons of alternative timing for the implementation of each design, including the sequence and rationale for the phasing in of the major components; and

(F) the pros and cons of each design option and of no changes to the current system.

(3) A comparative analysis of the coverage, benefits, payments, health care delivery, and other features in each design option with Vermont's current health care system and health care reform efforts, the new federal insurance exchange, insurance regulatory provisions, and other provisions in the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010. The comparative analysis should be in a format to allow the general assembly to compare easily each design option with the current system and efforts. If appropriate, the analysis shall include a comparison of financial or other changes in Medicaid and Medicaid-funded programs in a format currently used by the department of Vermont health access in order to compare the estimates for the design option to the most current actual expenditures available.

(4) A recommendation for which of the design options best meets the principles and goals outlined in Secs. 2 and 3 of this act in an affordable, timely, and efficient manner. The recommendation section of the proposal shall not be finalized until after the receipt of public input as provided for in subdivision (a)(1)(B) of this section.

(h) After receipt of the proposal and implementation plan pursuant to subdivision (g)(2) of this section, the general assembly shall solicit input from interested members of the public and engage in a full and open public review and hearing process on the proposal and implementation plan.