PERSPECTIVE

Vermont's Catamount Health: A Roadmap For Health Care Reform?

Massachusetts has received most of the policy and media attention, but Vermont's reforms might prove to be a more attractive—and viable—model for state reforms.

by Kenneth E. Thorpe

ABSTRACT: Vermont's new health reform program was enacted under a Republican governor in a state with a Democrat-controlled legislature. It thus serves as an intriguing approach to resolving political differences in health care. James Maxwell's interview of Vermont governor Jim Douglas provides background and insight on these reforms. I build on the interview, focusing on what changed between the 2005 reform failure and the passage of the new reforms. Key to the reform's political success was the recognition by both sides that it focused on issues of bipartisan concern: cost control through the effective management and prevention of disease. [*Health Affairs* 26, no. 6 (2007): w703–w705 (published online 16 October 2007; 10.1377/hlthaff.26.6.w703)]

WITH THE DEMOCRATS assuming control of Congress in 2006 and a presidential election in 2008, health care reform is likely to rise to the top of the domestic policy agenda. To date, developing consensus on reform has been contentious, leaving Congress, state governments, and Americans divided on the best path. One intriguing approach for cutting through the political divide was recently passed in Vermont. On 25 May 2006, Vermont's Gov. Jim Douglas (R) signed into law a sweeping set of health reforms known as Catamount Health and the Blueprint for Health. Catamount Health was enacted by a Republican governor and a Democratic legislature. Less than a year earlier, the governor vetoed a proposal for a publicly funded health care system (H. 524) during a contentious legislative session. Jim Maxwell's interview with Governor Douglas provides some insight and context for the reforms.[1] My thoughts build on that interview and focus on what changed between 2005—when the "Green Mountain" health reform plan failed—and the enactment of reform in 2006.

In 2005 the debate focused largely on how to finance coverage for the uninsured. As Governor Douglas noted in his interview, the basic discussion over Green Mountain Health was universal coverage and a contentious debate over a publicly financed health care system and the payroll tax required to finance it passed by the Vermont House. With reform defined as only for the uninsured (who constituted about 10 percent of the population), those with insurance were convinced that they would pay even more for health care and re-

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DOI 10.1377/hlthaff.26.6.w703

ceive less. Left out of the discussion was how health care reform would address a key concern facing the 90 percent of Vermonters with health insurance: the high and rising cost of health care.

Although universal coverage did not pass in 2005, important legislation was passed that provided funding for a new Commission on Health Care Reform and for the legislature to hold hearings throughout the state. The commission was cochaired by Senate health chair Jim Leddy and his counterpart in the House, John Tracy—both Democrats. Both Leddy and Tracy were in their last year of service and were eager to enact reforms. I was hired by the legislature as a consultant to the commission, tasked with developing new options for the 2006 legislative session. My sense was the legislature faced two options: to reintroduce a refined version of Green Mountain Health or, alternatively, reframe and broaden the debate to lead with clear proposals designed to lower the cost of health insurance for the 90 percent of Vermonters with health insurance. The first option would result in a predictable outcome: a veto and the inability of the House to muster up enough votes to override—a clearly unsatisfying result for the two key committee chairs in their last year. Yet the veto and failure to pass health care reform could serve as ammunition for the Democrats to use in the 2006 gubernatorial election against Governor Douglas. In contrast, the second option held the promise of reenergizing the debate, allowing the governor and the Democratic legislature to rebuild a working relationship to move health care reform along less partisan reform issues focusing on more effective management of chronic illnesses, prevention, and reducing administrative costs.

The bipartisan group of legislators selected option two and refocused the debate around key elements of cost control along with expanded health insurance coverage. The affordability focus provided the opportunity for a broader range of interests under the umbrella of the Campaign for Health Security—AARP, labor, the state education association, America's Agenda, and business coalitions—to more forcefully politically engage in the debate and help shape the legislation. After all, this time around, the primary focus was to make health care more affordable—an interest shared by Governor Douglas and the 90 percent of Vermonters with health insurance who felt burdened with high costs and meager coverage.

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■ **Facts shaping the debate.** Four "stylized" facts shaped the Vermont debate on how to make health care more affordable in 2006. (1) 75 percent of health care spending is associated with chronically ill patients—those with largely predictable, long-standing medical problems.[2] (2) The chronically ill only receive 56 percent of clinically recommended preventive care.[3] (3) Nearly two-thirds of the rise in health care spending is associated with rising rates of patients treated for diseases, largely chronic.[4] (4) Nearly 30 percent of the growth in health care spending is associated with the doubling of obesity over the past twenty years—a chief contributor to chronic illness.[5] Addressing the first two issues is a matter of appropriate medical management, not necessarily insurance. Moreover, building a modern, efficient, and high-quality health care delivery system designed to care for the chronic medical needs of patients and reducing obesity are not partisan issues per se. The clinical protocols for treating diabetes, hypertension, and other chronic conditions are well established in the provider community—our system just does not deliver them, since physicians and hospitals are not paid to provide them and we do not have a delivery model or modern information technology (IT) that facilitates it.

■ **Looking beyond the uninsured.** By refocusing the reform debate on broader sys-

temic ills facing health care, the Vermont legislature did not start with the politically charged and contentious issues of financing care for the uninsured. Instead, the discussion focused on areas of broad agreement—a set of "commonsense" reforms initially passed by the Senate that would modernize how care is delivered, create a statewide modern IT platform, and streamline health care administration. These are efforts the governor had been working on under the rubric of the Blueprint for Health. Engaging those with insurance as a centerpiece of the reforms also assuaged the concern accompanying most reform efforts: that those with coverage would pay higher premiums and more taxes but would receive the same or worse health care.

The final legislation included both the Blueprint for Health reforms designed to build a next-generation delivery system for managing chronically ill patients, new programs for preventing the rise in chronic disease, and a new insurance program for the uninsured—Catamount Health. By 2010, 96 percent of Vermonters will have health insurance coverage. Although there were clear differences in points of view on the structure and administration of Catamount Health between the governor and the legislature (was risk to be borne by private plans or a self-insured fund administered by private insurers?), ultimately the desire to pass this landmark legislation for the state meant compromises on all sides. By reframing the debate around the affordability of health care, the legislative leadership was able to craft a politically viable proposal that the governor ultimately signed.

Ironically, the Vermont plan passed because of and not in spite of its comprehensive approach for reforming health care. There were just too many "commonsense," nonpartisan improvements to the health care system included in the proposal not to enact it. Health care spending will rise at a slower rate—as a result of the innovative chronic care delivery model, new IT tools, effective efforts to prevent disease, and a reduction in hospital cost shifting. At the same time the introduction of the Catamount Health plan will allow the state to move toward universal coverage over the next four years.

Although Massachusetts has received most of the media and policy attention for its 2006 universal-coverage mandate, the Vermont reforms may ultimately prove a more attractive, and important, state and national model for health care reform.

NOTES

1. J. Maxwell, "Comprehensive Health Care Reform in Vermont: A Conversation with Governor Jim Douglas," *Health Affairs* 26, no. 6 (2007): w697–w702 (published online 16 October 2007; 10.1377/hlthaff.26.6.w697).
2. Centers for Disease Control and Prevention, "Chronic Disease Overview," 18 November 2005, http://www.cdc.gov/nccdphp/overview.htm (accessed 4 October 2007).
3. E.A. McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine* 348, no. 26 (2003): 2635–2645.
4. K. Thorpe, "The Rise in Health Care Spending and What to Do about It," *Health Affairs* 24, no. 6 (2005): 1436–1445.
5. K. Thorpe et al., "The Impact of Obesity on Rising Medical Spending," *Health Affairs* 23 (2004): w480–w486 (published online 20 October 2004; 10.1377/hlthaff.w4.480).