Human Rights Assessment of H.202 as Passed by the House

Assessment sections:
I. Roadmap, planning and governance
II. Vermont Health Benefits Exchange
III. Green Mountain Care

I. Roadmap, planning and governance

H.202 must establish our new healthcare system, not merely create a federally-mandated health insurance exchange and a public option. Green Mountain Care must be designed to work as independently as possible of decisions by the federal government over which we have no control. It must also be designed to work as the primary insurer for all Vermonters who do not receive federal healthcare benefits. Since healthcare is a public good, there cannot be a role for private insurance companies whose business model prioritizes private interests.

The bill should lay out a concrete and detailed plan for establishing a state-based universal, publicly funded healthcare system that starts enrolling Vermonters at the earliest possible date. Access to care for Vermonters must not be delayed to coincide with, or depend upon, potential federal funding, but should be made possible through equitable, public financing from the state.

The primary goal of this bill should be the establishment of a system that guarantees access to care for all Vermonters on an equal basis by providing healthcare as a public good. Controlling the system's costs is a means to that end, yet H.202 currently has these goals reversed by prioritizing cost containment.

1. Universality

All Vermonters must have access to comprehensive, quality health care. (Act 128, Sec.2(1))

The bill lacks a commitment to guaranteeing universal access as soon as possible. It does not add coverage for anyone for a number of years, until the Exchange comes into effect in 2014. Even then the increase of covered people is likely to be small. No attempt is made to provide universal coverage until 2017, when larger employers will be included in the exchange.

Green Mountain Care will not be implemented at all until a waiver under Section 1332 of the federal Patient Protection and Affordable Care Act ("ACA") is approved (waiver for state innovation). This necessitates a "Plan B" or a method for achieving universal care if a waiver is not available, if the ACA changes, is defunded, or fails to remain as is for any reason. This second path to universal care should be included in the bill.

It is unclear whether access to care will be fully comprehensive, i.e. include all care needed according to medical indications. While the bill states that Vermonters must have access to medically necessary care and that Green Mountain Care will provide comprehensive healthcare, it also references Catamount's benefits as a floor, and states that 13% cost-sharing would be acceptable. This results from an emphasis on cost containment, which suggests that cost imperatives take precedent, rather than the moral imperative of protecting people's health. Human rights principles do not allow prioritizing cost concerns over people's needs when needed resources can be identified.

2. Equity - Access

Systemic barriers must not prevent people from accessing necessary healthcare. (Act 128, Sec.2(1))

By planning a multi-year transition period (6 years), most Vermonters will continue to face severe barriers in accessing care over the next few years. During this transition period, Vermonters must purchase insurance policies, if they can afford them. Deductibles allowed by the ACA, co-pays and premiums endanger access for lower- and middle income Vermonters, since it has been proven that high costs (including premiums and cost-sharing) are one of the biggest barriers to access.

3. Equity-Financing

The financing of health care must be sufficient, fair, sustainable, and shared equitably. (Act 128, Sec.2(6))

The proposed Exchange is not financed equitably (see below), and the financing mechanism for Green Mountain Care has not been specified.

Financing during the transition period is predicated on the receipt of federal funds, which may not be sustainable or sufficient. Moreover, relying on the ACA's financing model (mandating the private purchase of insurance policies) may expose Vermont to the same uncertainties the federal law now faces due to current court challenges.

4. Transparency & Accountability

The healthcare system must be transparent in design, efficient in operation, and accountable to the people it serves. (Act 128, Sec.2 (2))

The governance mechanism of the transition phase lacks accountability to the people. The independent Board taking decisions on transition planning will be selected by a nominating committee made up of political and provider appointees, and includes no patients or community groups.

5. Participation

The state must ensure public participation in the design, implementation,

evaluation, and accountability mechanisms in the health care system. (Act 128, Sec.2(2))

People's participation in the planning and transition process is unclear, except in developing the GMC financing plan, which includes a public engagement process. This participation should be expanded to other transition issues. Community or grassroots groups should be represented in the transition process in order to make certain that there is meaningful participation from a broad cross-section of the people of Vermont, not just from professional interest groups.

6. Public Good

Healthcare is a public good for all Vermonters (Act 128, Sec. 8)

The transition process is predicated on treating health care as a market commodity; the Exchange is a marketplace.

II. Vermont Health Benefit Exchange

1. Universality

All Vermonters must have access to comprehensive, quality health care. (Act 128, Sec.2(1))

Not many new Vermonters will receive insurance, even once the Exchange becomes operational (not before 2014). Coverage will by no means be universal. Vermonters will be required to purchase private insurance in 2014, but there is no similar obligation on the state to make sure that everyone is able to do so or receives meaningful coverage in return.

Only Vermonters with the money to pay deductibles, premiums and co-pays will get access to healthcare if the implementation is managed according to the ACA (with the exception of those eligible for public programs such as Medicaid).

The Exchange excludes undocumented people based on the legal requirements of the ACA. There is a risk that other exclusions may be triggered by ACA requirements, such as an exclusion of comprehensive reproductive care. By implementing health reform according to ACA mandates, Vermont accepts those federal standards as guidelines, rather than the principles of Act 128.

2. Equity - Access

Systemic barriers must not prevent people from accessing necessary healthcare. (Act 128, Sec.2 (1))

The Exchange requires payment of premiums for access to care, which may constitute a barrier for low and middle income people. The subsidies provided under the ACA limits are likely to be insufficient to help many Vermonters gain access.

The Exchange explicitly allows deductibles, in addition to other forms of cost-sharing, which is likely to pose a significant barrier to access.

3. Equity-Financing

The financing of health care must be sufficient, fair, sustainable, and shared equitably. (Act 128, Sec.2(6))

The financing of healthcare through the Exchange is not equitable. Most Vermonters will have to buy a private health insurance policy (either through the Exchange or through their employer), so there is insufficient pooling of financial resources (apart from insufficient subsidies for low-income people) which would be needed to distribute contributions more equitably. Financing access to health care will remain an individual responsibility instead of a collective responsibility.

As we have seen from Vermont's experience with Catamount Health, attempts to expand coverage through facilitating the purchase of private sector insurance policies are unsustainable for the state and for individuals. Additionally, taxpayer dollars should not be used to subsidize additional private risk pool or pools, especially as the fragmentation of risk pools makes coverage more expensive and adds unnecessary administrative costs.

The financial burden will remain on people who get the sick, since the Exchange explicitly allows deductibles and other forms of cost-sharing.

Financing of coverage expansion through the Exchange may not be sustainable, as it depends upon the status of the ACA.

4. Transparency & Accountability

The healthcare system must be transparent in design, efficient in operation, and accountable to the people it serves. (Act 128, Sec.2(2))

The Exchange is a marketplace, even if hosted by the Vermont government. Unlike public goods, markets are not publicly accountable for operating in the public interest.

Although health insurers in the Exchange will need to have their rates approved, as they do now, and "provide accurate and timely disclosure" to the public on a certain issues, supported by so-called navigators, plans will continue to operate in accordance with their revenue imperatives, which lie outside the reach of public oversight.

5. Participation

The state must ensure public participation in the design, implementation, evaluation, and accountability mechanisms in the health care system. (Act 128, Sec.2(2))

There does not appear to be a public consultation process regarding setting up and running an Exchange.

6. Public Good
Healthcare is a public good for all Vermonters (Act 128, Sec. 8)

Healthcare continues to be a commodity under the ACA, and the Exchange mandated by the ACA.

III. Green Mountain Care

1. Universality
All Vermonters must have access to comprehensive, quality health care. (Act 128, Sec.2(1))

All residents appear to be included in Green Mountain Care, although a yet-to-be devised rule for proof of residency could disadvantage some segments of Vermont residents. Incompatible with human rights standards are the harsh financial penalties imposed if people receive healthcare yet their residency is challenged retrospectively. As the right and need to access care is universal, a punitive approach to limiting eligibility for a state-based program is inappropriate and unacceptable.

2. Equity - Access
Systemic barriers must not prevent people from accessing necessary healthcare. (Act 128, Sec.2(1))

Green Mountain Care leaves open the possibility of introducing cost-sharing, which could constitute a barrier to accessing needed care. All forms of cost-sharing, even at low levels, have been proven to deter access to needed care by those with limited means.

Cost-sharing would not be necessary if an equitable funding mechanism were developed that does not discriminate against sick people (see below).

3. Equity-Financing
The financing of health care must be sufficient, fair, sustainable, and shared equitably. (Act 128, Sec.2(6))

No financing mechanism is specified for Green Mountain Care. The bill does not even explicitly state that Green Mountain Care would be publicly financed.

The bill states that financing plans will be developed in consistency with the principle of equity. This would require progressive tax-based contributions from Vermonters according to their

abilities. Wealthier people, including those with investment incomes, should contribute in line with their means. Corporations should contribute according to their profitability.

If cost-sharing is implemented, the financial burden would disproportionately fall on those who get sick.

4. Transparency & Accountability

The healthcare system must be transparent in design, efficient in operation, and accountable to the people it serves. (Act 128, Sec.2(2))

Section 1826 (f) allows private insurance corporations to continue selling primary health coverage even after the implementation of GMC. This would continue the operations of a non-transparent, unaccountable marketplace, with little oversight and even less say for Vermonters, whose interests as policyholders are secondary to the private business interests of corporate insurers.

Section 1826 (a) allows for the Agency of Human Services to contract with private companies, including insurance companies, for the administration of certain elements of Green Mountain Care. Yet private entities, even when providing services to the state, are not required to operate in a fully transparent manner. Additionally, private entities are less accountable to the people than the state itself. There is also a risk that a private contractor could be in a position to deny Vermonters access to care, or to mismanage Vermonters' healthcare dollars.

It is unclear how the people of Vermont could hold the Board accountable, especially if there is no patient or people's representative on the Board. Recommendations from any advisory committees would have to have binding character in order to be a relevant element in an oversight process.

5. Participation

The state must ensure public participation in the design, implementation, evaluation, and accountability mechanisms in the health care system. (Act 128, Sec.2(2))

The development of a concrete financing plan for GMC will include a public engagement process (Section 9, (c)). There is also a public process regarding decisions about the Green Mountain Care benefit package. This should be expanded to other decisions by the Board and agency.

To ensure participation from the people of Vermont, the Board should include patients and representatives from community or grassroots groups.

Advisory committees may offer a limited opportunity for participation, but cannot replace participation in governance. The human rights principle of participation requires decision-making

powers, which advisory committees do not have, unless some mechanism is devised to enforce of recommendations through governance structures.

6. Public Good
Healthcare is a public good for all Vermonters (Act 128, Sec. 8)

To provide health care as a public good for Vermonters, the bill would have to rule out the treatment of health insurance as a commodity sold by private companies for private gain. Yet in the bill passed by the House, the designation of healthcare as a public good is contradicted by the permitted operation of private insurance companies whose business model is based upon the restriction of access to care for the generation of income. By allowing private insurance companies to operate within GMC - beyond the provision of supplemental policies - and by designating GMC only as secondary coverage, the bill, in Section 1826 (f), directly contravenes the principles of universal access and equity, and thus fails human rights standards. GMC would amount to nothing more than a public option in a private marketplace that restricts access to care based on insurance companies' business imperatives.

The private subcontracting of Green Mountain Care's administration (insurance carriers or other third parties will be invited to bid for certain aspects of administration) also puts Vermont's public good policy into question. At a minimum, the bill must state that the contractor's role will be for administrative processing only, with no decision-making or adjudicating power, and under strict oversight by the Agency and the Board. It must also state the Board will hold all third parties fully accountable for compliance with the principles in Section 9371 of this bill.