TRANSCRIPT: COMMENTS ON THE ORIGINAL LEGISLATION AND VERMONT HEALTH REFORM

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Good afternoon. My name is Steve Maier. Just another sentence or two about who I am and why I'm here; thank you Jackie[1] for the kind introduction and thank you for inviting me. You have heard the story already from the doctor here about where this whole business started here in New Hampshire. Where this particular legislation[2] that produced the *Sorrell* case[3] started was in my committee room in the Vermont legislature.

Up until about a year ago I served as chair of the Vermont House Health Care Committee, [and] so I have certain stories I could tell, certain perspectives I could bring to this conversation around that. I also just wanted to be clear about, like the doctor, I think I am the second panelist here today who is not an attorney. While I do have a VLS degree (1985), that degree is a Masters degree in environmental law, [and] so I can follow the conversation fairly well today; I did have constitutional law and some other things. I do not have a lot of wisdom to offer in the discourse of legal backs-and-forths about the First Amendment or about the dormant Commerce Clause or other things here so I think what I would like to offer is just a few comments about the general context within which the Vermont legislature passed this law and some of the other work we are doing in health reform. Not because it is necessarily directly on point with this case, but I think, at least since I have been sitting here today, I have been thinking about the work that is well underway in Vermont to reform our health care system, the work that is in front of us, if we are truly going to go to single-payer and trying to understand what implications if any this might have on that work.

So I will describe that work a little bit. And then I am just going to list at the end, after five minutes here of talking at you, I am going to list five or six things that occur to me that you might be interested in. I do not want to talk about them all. I would just like you to ask me questions; where would you like this to go in the remaining time? There is a lot of wisdom out there, so if you have thoughts about what we are trying to do in Vermont, if you

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† Please note that the Speaker reviewed and edited this Transcript. Language added by the *Vermont Law Review* appears in brackets, and ellipses indicate omissions of language.

1. Jackie Gardina, Professor of Law, Vermont Law School.
2. VT. STAT. ANN. tit. 18, § 4631 (2010).
3. Sorrell v. IMS Health Inc., 131 S. Ct. 2653 (2011).

have thoughts about single-payer or the earlier panel, the gentlemen who talked about this state taking on more of the power of the purse, becoming more of a market player in this, if there are limitations to that as you might see it, some of you legal scholars in the world of single-payer, I would be interested in hearing from you about that.

The issue in health reform, very generally speaking, is one of access, it is one of cost, and it is one of quality. When I first learned about health care, it was described to me as that three-legged stool between cost, quality, and access. The first thing I was told about it was that you could have any two of those you wanted, but not all three. I accepted that for a while, as truth, but what I have come to think I know is that the reform we are working on in Vermont is really trying to do all three. It is a big, complicated job. Even the Harvard consultant we hired last year to tell us how to do single-payer told us it would take us at least a decade to even begin to get there. We have been at it for five years now. Currently, we spend five billion dollars a year just in our little state, Vermont, on health care.[4] It's about 20% of gross state product.[5] We tell our sons and daughters, if you want a good job, go into health care. One of the few remaining jobs out there where you can make a real living wage is in the health care sector.

And yet at the same time, we policymakers and others are saying we have to reduce the cost of health care, we have to reduce things like salaries in health care because we cannot afford the trajectory that we are on in terms of health care spending. Within that large complicated picture we are trying to make progress in Vermont and I have to tell you, this idea, what became this bill,[6] what became this case,[7] was never the most important thing we were working on in terms of health care reform in Vermont, it was a piece we could do in the context of a bunch of other things we were trying to do. We have a dozen other (you have heard about some of them today) things we are doing just around pharmacy and even the pharmacy world, I would suggest, was sort of a minor part of what we've been trying to do. So, I guess the other thing I would like to say is that I came to health care as a politician, as a legislator, [and] my background is in environmental protection. I don't do that anymore. But when I learned about health care and the three-legged stool and everything else I brought to it the same

4. *See* VT. DEP'T OF BANKING, INS., SECS., & HEALTH CARE ADMIN., 2009 VERMONT HEALTH CARE EXPENDITURE ANALYSIS & THREE-YEAR FORECAST 4 (2011) (estimating $4.7 billion in total health care expenditures in Vermont in 2009).

5. *See id.* (quantifying health care spending as 18.5% of Vermont's gross state product in 2009).

6. tit. 18, § 4631.

7. *Sorrell*, 131 S. Ct. at 2653.

perspective I brought to it as a way-left leaning environmentalist, which is top-down, command-and-control legislation.

In Vermont, we are one of the few states that have health care planning on a statewide basis. We have health care certificate-of-need requirements so you cannot build an addition on a hospital unless you have this state's approval.[8] We still have those things. But I've pretty much come to the conclusion that that stuff does not work so well in the health care system. So I have evolved my thinking away from a top-down approach and now believe more strongly that what we need to do is fundamentally change the structures; the way we pay, how we pay, use in a targeted way. I don't believe that a competitive marketplace will work in health care, that's what got us into this mess, but in a targeted way change the way that we pay providers. We pay for sick care. We pay when someone is sick, we pay for visits, and we pay for volume. The hospital gets paid for an overnight stay or procedure, a doctor gets paid for a face-to-face visit, and the health care system gets paid when procedures are ordered.

So what do we get? We get lots of procedures, lots of visits, and lots of overnight stays, until we started to change the way we paid for health care. Create different incentives in the system, and you see what used to be in the 80s a six-, seven-day average stay in a hospital [is], in the course of two or three years . . . cut in half. So we are trying to apply some of those same principles in Vermont on payment streams, changing the way we deliver care on the ground, and changing some of the incentives built into the system, so that the top-down regulation is not so necessary.

There are six or seven more things we could talk about if you would like, and then I would like to present one use case that I would like to talk about if you would. I would be happy to talk more about how we developed the legislation; I have been tempted to react in some of my remarks here today to some of the things that have been said about me. But I am not, but I will if you want me to. We can talk more about health care reform in Vermont and single-payer and what the heck that's all about and how we think we can get there. I could talk more about citizen legislatures, and about state legislatures in general, and my thoughts about why state legislatures are more effective places to get things done, at least at this point in time, than our federal Congress.

But, what I have been involved with in the last year, especially as I have moved from being in the legislative branch to the executive branch in implementing health reform, is the use of data in some of these other reforms going forward. If we are not going to have, and we may still have,

8. VT. STAT. ANN. tit. 18, § 9434(b)(1) (2010).

but if we have less top-down regulatory authority going on in health reform, you need to have the flow of data to help you identify whether things are going right. If we think we want to move health care toward more effective, more efficient spending, some estimates are that 30% of that five billion dollars—so that is a lot of money: almost a billion and a half dollars—30% of that is unproductive spending [that] does not lead to any better health outcome.[9] If we want to take that money out and improve our outcomes, we need to have data and data sources and data systems that will feed to providers, patients, feed to us so that we can monitor the things that are going on. So that is the other thinking I have been having today, because we have been working on creating those data systems. We are not particularly interested in hiring IMS; . . . I had a conversation about this last night, but it is an interesting intellectual exercise that I have been forced to go through today as to how this case might affect our future work related to data and trying to change and move our health care system forward.

9. *See* LARRY MCNEELY & MICHAEL RUSSO, VT. PUB. INTEREST RESEARCH GROUP, HEALTH CARE IN CRISIS: HOW SPECIAL INTERESTS COULD DOUBLE HEALTH COSTS AND HOW WE CAN STOP IT 4 (2009) (applying nationwide estimates of one-third of health care expenditures as unproductive spending to Vermont's estimated health care expenditures).