State of Vermont
Agency of Administration

Overview of Vermont's Health Care Reform

October, 2006

INTRODUCTION

On May 25, 2006, Vermont Governor James Douglas signed into law Acts 190 and 191 (Acts Relating to Health Care Affordability for Vermonters). These Acts provide the foundation for Vermont's Health Care Reform Plan, augmented by portions of Act 215 (the Fiscal Year 2007 State Appropriations Act), Act 142 (Establishing a SorryWorks! Program), and Act 153 (Safe Staffing and Quality Patient Care).

Together, this comprehensive package of health care reform legislation is designed to simultaneously achieve the following three goals:

- ***Increase access to affordable health insurance for all Vermonters***
- ***Improve quality of care across the lifespan***
- ***Contain health care costs***

It is significant that Vermont's 2007 Health Care Reform Plan is the product of extensive negotiation and collaboration by the Douglas Administration, legislative leaders of the Vermont General Assembly, and the private sector participants in Vermont's health care system. While there were multiple ideas and political agendas as part of the discussions, there is agreement that the final legislation is comprehensive in its breadth and significant in its potential impact on health care in Vermont. There also is a commitment to move forward with implementation in a collaborative, non-partisan manner to maximize its success.

BACKGROUND - HEALTH CARE IN VERMONT

Good data on the demographics of the uninsured in Vermont from the 2005 Vermont Family Health Insurance Survey has helped to focus policy development. Fifty-one percent (51%) of the uninsured in Vermont are eligible for a Medicaid program but are not enrolled in the program. Twenty-seven percent (27%) of the uninsured in Vermont have household income under 300% FPL but are not eligible for a Medicaid program. Twenty-two percent (22%) of the uninsured in Vermont have household income greater than 300% of FPL and can afford to purchase health insurance.

Vermont has had significant experience using its Medicaid waiver authority to expand coverage for the uninsured. The Dr. Dynasaur program provides Medicaid coverage to all children with household income under 300% FPL, to pregnant women with household income under 200% FPL, and to parents and caretakers with household income under 185% FPL. The Vermont Health Access Plan (VHAP) provides coverage for uninsured adults with household income under 150% FPL and adults with children on Dr. Dynasaur with income under 185%, with no asset test. As a result, Vermont has an uninsured rate of 9.8% (61,056) compared with a national rate of 15.7%, and an uninsured rate for children of 4.9%.[1]

Per capita health care costs are lower in Vermont when compared to the U.S., but the spending gap has been narrowing since 1999. Health care spending growth rates in Vermont have exceeded national averages for each of the last six years. [2]

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[1] *Vermont Family Health Insurance Survey, 2005. The survey report can be found at http://www.bishca.state.vt.us/HcaDiv/Data_Reports/healthinsurmarket/2005_VHHIS_Final_080706.pdf*

[2] *The 2004 Vermont Health Care Expenditure Analysis can be found at http://www.bishca.state.vt.us/HcaDiv/Data_Reports/expenditure_analysis/2004EAReport.pdf.*

A major health care reform effort failed in Vermont in 1994 due in part to the inability of political leaders to reconcile the goal of covering the uninsured and the goal of containing costs for the insured.[3] This year's successful health care reform effort succeeded in part from a realization by many policy makers that the fundamental goals of health care reform are inter-related: (1) Covering the uninsured will help to lower uncompensated care costs, which affect premiums paid by the insured. (2) Unless health care costs can be brought within a more manageable rate of growth, Vermont will not be able to afford to cover the uninsured. (3) Public health initiatives and appropriate attention to healthy lifestyles and disease prevention are essential elements of an effective health care reform strategy.

VERMONT HEALTH CARE REFORM INITIATIVES

Following is a description of the goals, strategies, and specific initiatives of Vermont's health care reform:

GOAL: INCREASE ACCESS TO AFFORDABLE HEALTH INSURANCE FOR ALL VERMONTERS

- **Enhance Private Insurance Products**

1. *Catamount Health Plan.* A separate insurance pool is created for the purpose of offering a low cost health insurance product for uninsured[4] Vermonters. A comprehensive benefit plan will be provided under the Catamount Health policy, which is modeled after a preferred provider organization plan with a $250 deductible and $800 out of pocket maximum for individual coverage. Cost sharing is prescribed in statute, and includes a waiver of all cost-sharing for chronic care management and services, and a zero deductible for prescription drug coverage. Lower premium costs are anticipated based on estimates concerning the claims costs of the uninsured relative to the claims costs of the general population, and based on reimbursement rates established in the law that are lower than commercial rates (but 10% higher than Medicare rates). It is expected that Catamount Health policies will be offered to the uninsured by Blue Cross Blue Shield of Vermont, MVP, and Capital District Physicians Health Plan beginning October 1, 2007. The Health Care Reform Commission will review the Catamount Health insurance plans and the Catamount Health Assistance Programs by October 1, 2009 to determine the cost-effectiveness of the program, which may trigger discussions of an alternative approach to achieve the overarching goals of the health care reform.

2. *Non-group Market Consolidation Study.* A viable non-group market (where premiums are perceived as affordable and where enrollment is stable for all demographic groups without access to employer-sponsored insurance) is an essential component of a well-functioning, all-lines health insurance market. Like many other states, the Vermont non-group market is characterized by low enrollment, adverse selection, high prices, and limited carrier participation. Act 191 directs the state to study the impact of current trends, market rules

[3] *Leichter, Health Policy Reform in America: Innovations from the States. 1997.*

[4] *Uninsured means: 1) you have insurance which only covers hospital care OR doctor's visits (but not both); 2) you have not had private insurance for the past 12 months; 3) you had private insurance but lost it because you lost your job, got divorced, finished with COBRA coverage, had insurance through someone else who died, are no longer a dependent on your parent's insurance, or graduated, took a leave of absence, or finished college or university and got your insurance through school; or 4) you had VHAP or Medicaid but became ineligible for those programs.*

and laws on the non-group and small group markets and make recommendations to the General Assembly to improve this option for Vermonters.

3. *Local Health Care Coverage Pilot.* Although the state is now engaged through broad health care reform to provide and improve healthcare access and services for all Vermonters, there may be potential for other more localized models to address these concerns. Communities can play a key role in the availability of structures, facilities and services that support healthy behaviors and provide access to care. Act 191 provides funds to support a planning grant of $100,000 to one community organization or corporation to assist in establishing a local initiative to provide health care coverage or insurance to a community, region or geographic area of the state.

4. *Individual Insurance Mandate.* Act 191 requires that if less than 96% of Vermont's population is insured in 2010, the legislature must consider implementing a requirement that every Vermonter have health insurance.

- **Provide Assistance with Insurance Affordability**

1. *Catamount Health Premium Assistance Program.* A Vermont resident who has been uninsured for at least 12 months, who is not eligible for a public insurance program such as Medicaid, and who does not have access to an approved employer-sponsored insurance plan[5] may apply for financial assistance to purchase a Catamount Health policy at the following rates:

Under 200% FPL:	$60 per month
200-225% FPL:	$90 per month
225-250% FPL:	$110 per month
250-275% FPL:	$125 per month
275-300% FPL:	$135 per month
Over 300% FPL:	full cost of the Catamount Health policy (approx. $360)

2. *Employer Sponsored Insurance (ESI) Premium Assistance Program.* If cost-effective for the state, adults currently enrolled in the Medicaid VHAP program and new VHAP applicants who have access to an approved employer-sponsored insurance (ESI) plan[6] will be required to enroll in the employer-sponsored plan as a condition of continued premium assistance or coverage under VHAP. The premium assistance program will provide a subsidy of premiums or cost-sharing amounts based on the household income of the eligible individual to ensure that the individual out-of-pocket obligations for premiums and cost-sharing amounts are substantially equivalent to or less than the annual premium and cost-sharing

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[5] *At minimum, an approved employer-sponsored insurance plan for Catamount ESI Premium Assistance would be required to conform to the following standards: 1)the benefits covered by the plan must be substantially similar to the benefits covered under Catamount Health; 2) appropriate coverage of chronic conditions in a manner consistent with statewide participation by health insurers in the Vermont Blueprint for Health; and 3) after statewide participation is achieved, coverage of chronic conditions substantially similar to Catamount Health.*

[6] *At minimum, an approved employer-sponsored insurance plan for VHAP-ESI Premium Assistance would be required to conform to the following standards: 1)the benefits covered by the plan must be substantially similar to the benefits covered under the certificates of coverage offered by the typical benefit plans issued by the four health insurers with the greatest number of covered lives in the small group and association market in the State, and 2) the plan must include appropriate coverage of chronic conditions in a manner consistent with statewide participation by health insurers in the Vermont Blueprint for Health.*

obligations under VHAP. In addition, supplemental benefits or "wrap-around" coverage will be offered to ensure VHAP enrollees continue to receive the full scope of benefits available under VHAP.

The ESI Premium Assistance Program also will make health coverage more affordable for uninsured low-income Vermonters who are not eligible for Medicaid or VHAP, have incomes under 300 percent FPL, and who have access to an approved employer-sponsored coverage. The ESI Premium Assistance Program will provide a subsidy of premiums or cost-sharing amounts based on the household income of the eligible individual, with greater amounts of financial assistance provided to eligible individuals with lower household income and lesser amounts of assistance provided to eligible individuals with higher household income. However, if providing the individual with assistance to purchase Catamount Health is more cost-effective to the State than providing the individual with premium assistance to purchase the individual's approved employer-sponsored plan, the State shall enroll the individual in the Catamount Health Assistance Program.

3. *Decreases in VHAP Premiums.* Premiums for children enrolled in the Medicaid Dr. Dynasaur program were decreased by 50%. Premiums for adults in the Medicaid VHAP program were decreased by 35%.
4. *Non-Group Market Security Trust.* The purpose of this trust is to reduce premiums in the non-group market by a minimum of 5% to make these products more affordable for individual Vermonters. State funds have been committed to this Trust, and Vermont also has been awarded a grant from CMS for start-up expenses.

- **Improve Outreach to the Uninsured**

1. *Medicaid Enrollment Initiatives.* Fifty-one percent (51%) of the uninsured in Vermont are eligible for but not enrolled in a Medicaid program. The health care reform legislation requires a report to be completed by stakeholders and the state regarding how to improve outreach activities for these individuals.
2. *Toll-free Number.* The legislation also calls for the Agency of Human Services to implement an aggressive outreach campaign and toll-free help-line to assist individuals with Catamount Health and the premium assistance programs. This will augment the already-existing toll-free help line for Medicaid, VHAP and Dr. Dynasaur.

GOAL: IMPROVE QUALITY OF CARE ACROSS THE LIFESPAN

- **Improve Chronic Care Management**

1. *Blueprint for Health - the State's Chronic Care Plan.* Chronic conditions are the leading cause of illness, disability, and death in Vermont. More than half of all Vermont adults have one or more chronic conditions (e.g., diabetes, hypertension, cardiovascular disease, asthma, arthritis, cancer, respiratory diseases, depression and other mental health disorders, substance dependence and many others). Caring for Vermonters with chronic conditions consumes more than three-quarters of the $2.8 billion spent in the state each year on health

care.[7] As such, Vermont has decided to invest significant public funds in the redesign of the health care system to improve the quality and cost-effectiveness of care for those with chronic conditions.

Launched in 2003 by Governor James Douglas as a public–private partnership, the Blueprint for Health was fully endorsed in Act 191 of 2006 as Vermont's plan to have a systemic statewide system of care that improves the lives of individuals with, and at risk for, chronic conditions.[8] The Blueprint model focuses on five change areas:

- *Patient Self-management*. The patient will actively manage and be responsible for his or her own care in collaboration with a health care team.
- *Provider Practice Change*. Patients will receive care consistent with evidence-based standards, and financial incentives will be aligned with treatment consistent with those standards.
- *Community Activation and Support*. Communities will become engaged in public health at the local level to address physical inactivity and obesity, which are risk factors for many chronic diseases.
- *Information Technology*. A Chronic Care Information System will be developed that supports statewide implementation of the Blueprint for both individual and population based care management.
- *Health System Design*. The Blueprint collaborative will develop common performance measures and clinical guidelines for chronic conditions, and link financing mechanisms and insurance reimbursement with the attainment of chronic care treatment goals.[i]

The Blueprint initially focused on two Vermont communities, and is expanding to several more in 2007. Act 191 requires that the Blueprint be implemented statewide by 2009, and that other chronic care initiatives within the reform package (described below) align with the Blueprint priorities and projects.

2. *OVHA Chronic Care Management Program (CCMP).* The Office of Vermont Health Access (OVHA), the state's Medicaid agency, is required to develop a chronic care management program, consistent with the policies and standards established by the Blueprint for Health, through a contract with a private company for the 25% of Vermonters enrolled in Medicaid, Dr. Dynasaur and VHAP.

3. *Medicaid Reimbursement Incentives for participating in CCMP.* OVHA also is mandated to determine how to restructure payment to health care professionals for chronic care to pay doctors to provide the right care at the right time. They also will provide incentive payments to health care professionals participating in the Medicaid care coordination program; and reimbursement increases in the future will be tied to performance measures established by the Blueprint for Health - the Chronic Care Initiative.

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[7] It is estimated that in excess of $2.3 billion was spent on chronic conditions in Vermont in 2002, including approximately $407 million in Medicaid spending. *Vermont Health Care Expenditure Analysis 2002*. Vermont Dept. of Banking, Insurance, Securities, and Health Care Administration.

[8] The Vermont Department of Health is responsible for the development and implementation of the Blueprint for Health. Additional information on the Blueprint for Health is provided at http://healthvermont.gov/blueprint.aspx

4. *State Employee Health Benefits Program Alignment with Blueprint.* The state's self-insured health care plan for employees was required to include alignment with the Blueprint as a component of the contract re-bid process in 2006.
5. *Employer-Sponsored Insurance (ESI) Premium Assistance Coverage.* ESI plans approved by the state for the premium assistance programs must include chronic care coverage consistent with Blueprint. In addition, the state's premium assistance program will cover all chronic care cost-sharing amounts for beneficiaries enrolled in a chronic care management program.
6. *Catamount Health Plan Chronic Care.* The Catamount Health Plans are required to have a chronic care management program, and to waive cost-sharing for chronic care for individuals participating in chronic care management.
7. *Chronic Fatigue Syndrome Informational Packets.* The Vermont Department of Health was required to develop and broadly distribute information on this often-hidden syndrome.

- **Increase Provider Access to Patient Medical Information**

1. *Health Information Technology.* The Health Care Reform financially supports the Vermont Information Technology Leaders (VITL), a public-private partnership, as the entity to develop the statewide, integrated, electronic health information infrastructure for the sharing of health information among health care facilities, health care professional, public and private payers, and patients. As a first step, the Medication History Pilot Project will reduce the risk of adverse drug events; improve the quality of health care for many Vermonters, and save health care costs. VITL also is the conduit for the Chronic Care Management Information System to support the Blueprint for Health. The legislation also requires that VITL develop a State Health Care Information Technology Plan to address issues related to data ownership, governance, and confidentiality and security of patient information.
2. *Master Provider Index for Vermont Health Care Professionals.* A work group of the Area Health Education Centers (AHEC) Program of the University of Vermont College of Medicine is charged with developing recommendations about how to create a master provider index for information technology referencing purposes.
3. *Loan Program for Physician Electronic Medical Records Infrastructure.* The legislation requires that the State develop a loan and grant program for electronic medical records at primary care practices, and that implementation be a component of the VITL State Health Care Information Technology Plan.

- **Promote Wellness**

1. *Free Immunizations.* Starting October 1, 2007, clinically recommended immunizations will be provided to all Vermonters across the lifespan at no cost when not otherwise reimbursed.

2. *CHAMPPS (Coordinated Healthy Activity, Motivation and Prevention Program).* Vermont has recognized that public health concerns such as those relating to overweight and poor nutrition are major drivers in the incidence of chronic disease incidence, and in increased medical inflation. CHAMPPS will provide competitive multi-year grants to communities to assist them in promoting healthy behavior and disease prevention across the lifespan of the individual, consistent with the Blueprint and community goals. Examples include the promotion of good nutrition and exercise for children, community recreation programs,

elderly wellness, lead poisoning abatement, obesity prevention, maternal and child health and immunization, and tobacco prevention and cessation programs.

3. *Catamount Health Plan Care*. The Catamount Health Plans are required to include preventive care, and to waive cost-sharing for treatments.

4. *Healthy Choices Insurance Discount.* The Catamount Health legislation authorizes the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) to adopt regulations permitting health insurers to establish premium discounts (up to 15% of premiums) or other economic rewards for insured's in Vermont's community rated non-group and small group markets. Premium discounts will be available for those who participate in programs of health promotion and disease prevention.

- **Increase Provider Availability**

1. *Loan Repayment Program.* Recognizing the need to attract and retain providers in underserved specialties and geographic areas, the legislation authorizes awards to Vermont health care providers and educators that meet these criteria who have outstanding loans, with the agreement that they will serve patients with Medicare, Medicaid, or state health benefit coverage

2. *Loan Forgiveness Program.* The legislation also augments an existing loan forgiveness program for dental hygienists and nurses, specialties that hard to recruit and retain in Vermont.

3. *Funds for FQHC Look-alikes, Uncompensated Care Pool.* Uncompensated care pool funds were designated for an income-sensitized sliding scale fee schedule for patients at FQHC look-alikes. The goal is to provide equal geographic distribution of funds to ensure an FQHC look-alike in every county.

- **Promote Quality Improvement**

1. *Consumer Price and Quality Information System.* A major factor in the success of consumer driven health care plans is consumer access to good price and quality information. This is especially important as more benefit plans require higher levels of out of pocket spending. The Health Care Reform legislation directs the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) to adopt rules for health insurers to provide transparent price and quality information so that consumers are empowered to make economically sound and medically appropriate decisions.

2. *Multi-payer Data Collection Project.* Health care providers, hospitals, insurers and the state need a comprehensive health information system in order to improve the quality and cost-effectiveness of the health care system. Modeled after programs in Maine and New Hampshire, BISHCA is directed to design the data collection program and to begin program implementation.

3. *Adverse Event Reporting.* The Vermont Department of Health is required to develop a Patient Safety Surveillance and Improvement System, designed to be used within Vermont hospitals to improve patient safety, eliminate adverse events, and support quality improvement efforts. Hospitals must track adverse events and analyze the causes, with protections for patient confidentiality and peer review, and they must report to patients or family when an adverse event causes death or serious bodily injury. Information on hospital adverse events and

infections will be reported to the public on an annual basis through hospital community reports.

4. *Safe Staffing.* Hospital nurse to patient ratios and other nurse staffing measures now must be made available to patients and the public.

5. *SorryWorks!* Another component of the health care reform legislation is a voluntary, pilot SorryWorks! program in which physicians and hospitals promptly acknowledge and apologize for mistakes in patient care that result in harm and promptly offer fair settlements. Such an oral apology or explanation of how the medical error occurred, made within 30 days, may not be used to prove liability, is not admissible, and cannot serve as the subject of questioning in administrative or civil proceedings. Negotiations under SorryWorks! are confidential, and the statute of limitations is tolled during negotiations. A settlement resulting from participation in the SorryWorks! program bars further litigation; if settlement is not reached, the patient may bring a civil action.

6. *Advanced Directives.* The health care reform legislation enhances Vermont's Advanced Directives statutes by requiring health care providers to notify the registry and submit a copy of any amendments, suspensions, and revocations about which it knows. It also clarifies that an advance directive can specify who can and cannot bring probate court action and the probate court must honor this. The law is also applied to "procurement organizations" as appropriate.

GOAL: CONTAIN HEALTH CARE COSTS

- **Increasing Access to Insurance and Improving Quality of Care**

1. All of the initiatives described above that increase insurance coverage and improve quality of care are expected to have a direct effect on containing Vermont's health care costs. For example, reducing the number of uninsured and underinsured people, increasing the rates paid by public health insurance programs, and assisting enrollment in employer-sponsored insurance programs will reduce the cost shift, which in turn will reduce increases in health care premiums. In addition, the Blueprint and the multiple other efforts related to prevention and chronic care are built on the premise that preventing disease and improving the quality of care for people with chronic illness are effective ways to reduce the overall demand for high-cost treatment services and reduce health care costs throughout the system. Improved quality of care and cost savings also are anticipated from implementation of many other initiatives, including the provision of transparent price and quality information, the adverse events system, and SorryWorks! In addition, there are specific initiatives described below that are aimed at directly decreasing the cost shift and improving administrative efficiencies to control escalating costs.

- **Decrease Cost Shift**

1. *Medicaid Provider Reimbursement Increases.* Significant Medicaid provider underpayments can threaten access to care, and underpayments result in a cost shift to commercial plans that must be paid by commercial health insurance premiums. To begin to address this, the Health Care Reform legislation increases Medicaid provider reimbursements in the following manner: (i) evaluation and management services will be paid at Medicare rates in order to support primary care physician practices; (ii) supplemental payments will be provided to

dentists with high Medicaid patient counts; and (iii) hospital rates will be increased annually until the federal upper limit is reached.

2. *Other Cost Shift Initiatives.* Individuals and businesses who pay commercial health insurance premiums pay additional premium because of the shifting of costs attributable to the uncompensated care of the uninsured, and attributable to Medicaid and Medicare underpayments. The Department of Banking, Insurance, Securities and Health Care Administration will undertake several cost shift initiatives, including:
    - Requiring hospitals to account for Medicaid reimbursement increases in their annual budgets established by the Department.
    - Standardizing hospital bad debt and free care policies.
    - Developing procedures to account for changes in uncompensated care and Medicaid reimbursement when the Department approves health insurance rates.

- **Simplify Health Care Administration**

1. *Common Claims and Procedures.* The Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) is charged with adopting regulations designed to simplify the claims administration process, and to lower administrative costs in the health care financing system. The Department will prescribe a uniform provider credentialing form for use by hospitals and health insurance companies on January 1, 2007.
2. *Uniform Provider Credentialing.* BISHCA is also charged with setting a standard form and process to be used insurers and hospitals for credentialing their providers.

FINANCING VERMONT'S HEALTH CARE REFORM

Funding for the programs within Vermont's Health Care Reform is based on the principle that everybody is covered and everybody pays.

- ***Catamount Health Plan*:** Individuals pay sliding scale premiums based on income.

- ***Increases in Tobacco Product Taxes*:**
    - A $.60 per pack increase in the cigarette tax beginning July 1, 2006 and an additional $.20 per pack increase beginning July 1, 2008.
    - A new tax on "little cigars" and roll-your-own tobacco as cigarettes.
    - Changes the method of taxing moist snuff to a per-ounce basis and increases tax on July 1, 2008 by 17 cents.

- ***Employers' Health Care Premium Contribution.*** Employers will pay an assessment based on their number of "uncovered" employees, based on the following guidelines:
    - Employers without a plan that pays some part of the cost of heath insurance of its workers must pay the health care assessment on all their employees.
    - Employers who offer health insurance coverage must pay the assessment on workers who are ineligible to participate in the health care plan, and on workers who refuse the employer's health care coverage and do not have coverage from some other source.

  The assessment is based on full-time equivalents at the rate of $91.25 per quarter ($365 per year), exempting eight FTEs in fiscal years 2007 and 2008, six FTEs in 2009, and four FTEs in and

after 2010. The assessment rate will increase annually indexed to Catamount Health Plan premium growth.

- ***Medicaid Global Commitment to Health Waiver***. In 2005 Vermont entered into a new five year comprehensive 1115 federal Medicaid demonstration waiver designed to: 1) provide the state with financial and programmatic flexibility to help Vermont maintain its broad public health care coverage and provide more effective services; 2) continue to lead the nation in exploring new ways to reduce the number of uninsured citizens; and 3) foster innovation in health care by focusing on health care outcomes. The Waiver program consolidates funding for all of the state's Medicaid programs, except for the new Choices for Care (long-term care) waiver and several small programs (SCHIP and DSH payments for hospitals). It also converts the Office of Vermont Health Access (OVHA), the state's Medicaid organization, to a public Managed Care Organization (MCO). Under this new waiver, the MCO can invest in health services that typically would not be covered in our Medicaid program, and Vermont's Medicaid program has programmatic flexibility to implement creative programs and reimbursement mechanisms to help curb our health care costs. The State has requested an amendment from CMS to include Catamount Health and the employer-sponsored insurance premium assistance programs under the financial umbrella of this waiver.
- ***Savings in the Medicaid VHAP program due to employer-sponsored insurance enrollment.***
- ***State General Fund appropriations.***
- ***State fiscal obligations protected.*** The legislation enables the state Emergency Board to establish caps on enrollment in the Premium Assistance Programs if sufficient funds are not available to sustain the programs.

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