health internationally, suggesting a dietary template that may be of particular value as chronic disease becomes a global issue.

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1. Sofi F, Abbate R, Gensini GF, Casini A. Accruing evidence on benefits of adherence to the Mediterranean diet on health: an updated systematic review and meta-analysis. Am J Clin Nutr 2010;92:1189-96.
2. Allbaugh LG. Crete — a case study of an underdeveloped area. Princeton, NJ: Princeton University Press, 1953.
3. Jacobs DR Jr, Tapsell LC. Food, not nutrients, is the fundamental unit in nutrition. Nutr Rev 2007;65:439-50.
4. Nestle M. Mediterranean diets — historical and research overview. Am J Clin Nutr 1995;61:Suppl:1313S-1320S.
5. Datz T. Harvard serves up its own 'plate': Healthy Eating Plate shows shortcomings in government's MyPlate. Harvard Gazette. September 24, 2011 (http://news.harvard.edu/gazette/story/2011/09/harvard-serves-up-its-own-plate/).

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Lessons from Vermont's Health Care Reform

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In May 2011, Vermont Governor Peter Shumlin signed legislation to implement Green Mountain Care (GMC), a single-payer, publicly financed, universal health care system. Vermont's reform law passed 15 months after the historic federal Affordable Care Act (ACA) became law. In passing reforms, Vermont took matters into its own hands and is well ahead of most other states in its efforts to implement federal and state health care reforms by 2014. The Supreme Court decision last June to uphold most of the ACA left many states scrambling, since they had postponed reforms pending the judgment. Although Vermont is a small state, its reform efforts provide valuable lessons for other states in implementing ACA reforms.

First, Vermont instigated change from within the state and engaged local stakeholders in the process. Vermont's administration provided information to residents, promoted transparency, and actively engaged citizens on all levels. The administration established a health care reform website, hcr.vermont.gov, which provides regular reform updates, educational presentations, timelines, and links to legislation and other reform resources. Administrators host frequent public listening sessions throughout the state. In addition, Shumlin engaged health care providers in the reform process, in part through the GMC Health Care Professional Technical Advisory Group, which consists of 68 physicians, dentists, physical and occupational therapists, pharmacists, and naturopathic doctors, and the Mental Health and Substance Abuse Technical Advisory Group, consisting of 24 mental health professionals. The engagement of such stakeholders has helped to smooth the transition to large-scale reform.

Second, Vermont created the Green Mountain Care Board (GMCB), an independent board with responsibility for all the major factors influencing the cost of health care in the state. Whereas other states split responsibility for the oversight of different parts of the health system among different agencies, Vermont's legislature created one board to consider all the variables. The GMCB has jurisdiction over payment reform, insurance exchanges, rate setting, hospital-budget authorization, resource and workforce allocation, state formulary establishment, regulation of insurance carriers, and maintenance of a statewide quality-assurance program. The board will establish and maintain a publicly financed health insurance program and a unified health budget. In addition, it is overseeing the development of two accountable care organizations: the Accountable Care Coalition of the Green Mountains, which includes 100 independent physicians statewide, and OneCare Vermont, whose network of 13 community hospitals, 2 federally qualified health clinics, 5 rural health centers, and 58 independent physician practices is responsible for the care of 42,000 Medicare recipients. The fact that many types of health care–related transactions must pass through the GMCB supports synchronization of reform efforts.

Third, Vermont is advanced in its development of a state insurance exchange that will offer essential benefits through at least three tiers of insurance packages while providing transparency and comparability.[1] The ACA mandates that states establish their own exchanges or default to the federal exchange, and to date 23 states and the District of Columbia have declared their intent to establish their own exchange or a joint state–federal exchange (see table).[2] Although the development of a state exchange is a massive task, Vermont administrators believe that their exchange will serve as a foundation for a streamlined system for single-payer reform. "The infrastructure is useful because it would build the portal we would use for single payer, including eligibility screening, enrollment processing, premium collection, claims administration, and claims payment," notes Robin Lunge, Ver-

States That Have Declared Their Plans to Create State-Based or State–Federal Health Insurance Exchanges.

State-Based Exchanges

California	Minnesota
Colorado	Nevada
Connecticut	New Mexico
District of Columbia	New York
Hawaii	Oregon
Idaho	Rhode Island
Kentucky	Utah
Maryland	Vermont
Massachusetts	Washington

State–Federal Exchange Partnerships

Arkansas	Iowa
Delaware	New Hampshire
Illinois	West Virginia

mont's director of health care reform. "We have 65 small group plans in the state. With only two carriers in the state and on the exchange, the plans will be more uniform and there will be significantly less product. In terms of competition and cost control, Vermont has a rigorous rate-review process to look at insurance premiums to make sure they are reasonable given the factors established in state law." Establishment of a state exchange will provide Vermont with several advantages, including federal funding, the development of an electronic portal for insurers, and the opportunity to align state reforms with federal ones as much as possible.

Finally, Vermont policymakers are maximizing federal financing and have projected cost savings. In January 2013, the state released a 156-page financing plan for its single-payer arrangement; the plan outlines federal financing sources and the anticipated generation of savings. Vermont has been awarded more than $250 million in federal funding for its state exchange — the fifth-highest amount among the states, although Vermont has the country's second-smallest state population. "We feel strongly that the exchange is not the answer to all of Vermont's health care problems," Shumlin remarked, explaining that "the exchange is helpful to Vermont to bring us federal dollars to achieve our single-payer goal."[3] In fact, state exchange development will be 100% federally funded.[4]

Vermont will also gain substantial federal funding through its Medicaid expansion ($249 million) and attract federal financing through a 2017 innovation waiver ($267 million). While many states continue to debate expansion, Vermont has expanded its Medicaid program well beyond the ACA's proposed income-eligibility threshold of 138% of the federal poverty level. With the expansion, Vermont will save 10.9% in state Medicaid funding. States that now have high eligibility levels will see decreases in spending, whereas those with low eligibility levels will have to increase their spending. Overall, experts predict that the national impact of Medicaid expansion will be a net increase of 0.3% in states' total Medicaid expenditures but an overall decrease of 0.4% in spending, thanks to a 0.7% decrease in uncompensated care. Even though some states will see an eventual increase in spending on Medicaid if they expand their programs, they will still generate net savings in health care spending.[5]

Revenues from taxes (payroll, personal income, sales, cigarettes, tobacco, insurance, and more) will also finance GMC, but administrators believe that the eventual cost savings from the single-payer system will be greater than what will initially be needed from tax revenues. In 2017, claims costs are projected to be $87 million higher than they would have been without health care reform because additional health care services will be provided, but administrative costs will be $122 million lower, which will result in net savings of $35 million in the first year.

Policymakers and stakeholders in other states can learn some lessons from Vermont regarding ACA reform. First, engaging stakeholders while providing transparency at each stage of reform builds support for transition efforts. Second, the adage "work smarter, not harder" applies to the enormous task of implementing health care reforms: a central board can coordinate all implementation efforts, reduce redundancy and bureaucracy, and improve transparency. Third, the development of a health insurance exchange presents opportunities for state-specific health care innovation. And finally, instead of resisting the inevitable federal reforms in the name of federalism, states may capitalize on federal financing opportunities to build new state health programs and realize cost savings.

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1. Lunge R. The Vermont health benefit exchange (PowerPoint presentation). 2012 (http://hcr.vermont.gov/sites/hcr/files/Exchange%20benefits%20report%20Feb%202012%20FINAL.pdf).
2. Henry J. Kaiser Family Foundation. Facts at-a-glance (http://www.statehealthfacts.org/healthreformsource.jsp).
3. Panebaker A. Shumlin bends on health benefits exchange. VTDigger.com. February 7, 2012 (http://vtdigger.org/2012/02/07/shumlin-bends-on-health-benefits-exchange/).
4. Lunge R, Larson M. Financing plans 2014-2017 (PowerPoint presentation). January 25, 2013 (http://hcr.vermont.gov/sites/hcr/files/2013/Financing%20Plans%20PPT%20w%202017%201-25%20Final.pdf).
5. Henry J. Kaiser Family Foundation. The cost and coverage implications of the ACA Medicaid expansion: national and state-by-state analysis. November 2012 (http://www.kff.org/medicaid/upload/8384.pdf).

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