A Buy-in to the Vermont Health Access Program (VHAP) for Individuals and Small Employers: Cost and Coverage Impacts

Final Report

prepared for:

The Office of Vermont Health Access (OVHA)

by:

The Lewin Group

February 9, 2004

Supported in part by a grant to the VT Agency of Human Services from the Health Resources and Services Administration, U.S. Department of Health and Human Services

Table of Contents

EXECUTIVE SUMMARY ____ **I**

A BUY-IN TO THE VERMONT HEALTH ACCESS PROGRAM (VHAP) FOR ____ **1**

INDIVIDUALS AND SMALL EMPLOYERS ____ **1**

A. VHAP BUY-IN DESCRIPTION ____ **1**

1. Current VHAP Program ____ *1*

2. Buy-in to VHAP for Employers and Individuals ____ *3*

3. VHAP Buy-in Provider Payment Levels ____ *4*

4. VHAP Buy-in Benefits ____ *5*

B. KEY ASSUMPTIONS ____ **5**

1. Model Overview ____ *6*

2. VHAP Buy-in Premium ____ *7*

3. Individuals Buying into VHAP ____ *10*

4. Employer Decision to Buy-in to VHAP ____ *11*

5. Utilization Response ____ *12*

6. Payment Levels and Cost Shifting ____ *12*

C. PROGRAM IMPACTS ____ **13**

1. Enrollment and Costs Under the VHAP Buy-in Proposal ____ *13*

2. Impact on Sources of Insurance ____ *14*

3. Impact on State-Wide Health Expenditures ____ *16*

4. Impact on State Government Health Spending ____ *18*

5. Federal Expenditures ____ *19*

6. Private Employer Impacts ____ *19*

7. Impact on Household Health Spending ____ *20*

D. RESERVE REQUIREMENTS ____ **22**

1. IBNR Reserve ____ *23*

2. Claim Fluctuation Reserve ____ *24*

E. SELECTION EFFECTS ____ **26**

F. ALTERNATIVE BUY-IN ELIGIBILITY CRITERIA ____ **27**

1. Alternative Eligibility Criteria ____ *28*

2. Impact on Insurance Markets ____ *28*

3. Cost Shifting ____ *32*

G. CONCLUSIONS ____ **33**

Executive Summary

The purpose of this analysis is to estimate the impact of a program that would permit low-income individuals and small employers with low-wage workers to enroll in the Vermont Health Access Program (VHAP). The program would be fully funded with premium payments by participants. For many individuals and employers this would be a lower-cost health insurance option primarily because provider payment levels under the program would be substantially lower than provider payments under commercial insurance for comparable services.

The availability of this lower-cost option is designed to expand health insurance coverage in Vermont. However, as we discuss below, the lower premium under the Buy-in would also attract large numbers of individuals and employers who are already offering coverage. This could result in increased cost-shifting and a reduction in the number of insurers who are willing to provide coverage in the Vermont insurance markets. Thus, we also examined variations on the VHAP Buy-in model designed to avert this loss of insurers.

Benefits Package

The benefits provided under the program are designed to be consistent with health plans typically available in the small group and individual insurance markets. We assume that the program covers inpatient and outpatient hospital care, emergency care, physicians care and prescription drugs. We assume that the program requires $20 co-payments for physician office visits subject to an overall annual deductible of $500 for people in small groups. Because deductibles are typically higher in the non-group market, we assume that there would be a $3,000 deductible for people purchasing coverage under the Buy-in as individuals.

A major feature of the VHAP Buy-in is that it would pay providers at 110 percent of Medicare payment levels, which are about 25 percent less than what commercial insurers are paying for comparable services. Data provided by the Department of Banking, Insurance, Securities and Health Care (BISHCA) and Mercer indicate that 110 percent of Medicare payment levels would be lower than what commercial insurers are paying by about 23 percent for hospital care and about 27 percent for physician care. In addition, we assume that the program would receive the same manufacturer rebates currently received by the Vermont Medicaid program (i.e., about 21.5 percent). These lower payment levels would result in a Buy-in premium that is substantially lower than commercial insurers are charging for comparable coverage.

The premiums paid by enrollees would be set at levels sufficient to cover the full cost of providing these benefits to enrollees, so that the program is fully funded by participant premiums. We estimate that the monthly premium for the VHAP Buy-in in 2004 would be about $235 per adult and about $106 per child for small groups enrolling in the Buy-in. The premiums for people purchasing Buy-in coverage as individuals would be about $207 for adults and $79 for children. These premiums are about 25 percent lower than premiums for comparable coverage in these markets, primarily due to the lower payment rates under the

program. Our premium estimates are substantially the same as estimated for the program in a separate project by Mercer.[1]

Eligibility

We estimated the cost and coverage impacts of the Buy-in under five different eligibility scenarios. Our first eligibility scenario, which we refer to a scenario # 1, is based upon legislation introduced in 2002 that would have created a Buy-in program. Under this scenario, the Buy-in is available to all individuals without access to employer coverage who have incomes below 300 percent of the FPL. The Buy-in is also available to firms with 25 or fewer workers who have an average payroll of less than $31,000 per worker (i.e., average earnings for workers in small firms in Vermont).

We estimate that there are about 91,076 people who are eligible under this scenario of whom about 47,129 people would enroll (***Figure ES-1***). Of those who enroll, about 7,158 would be uninsured people who either decide to purchase Buy-in coverage as individuals or are employed in an eligible non-insuring firm that decides to start providing Buy-in coverage. The remaining 39,971 people are currently insured people who shift from commercial coverage to the Buy-in to take advantage of the lower premiums. The program would cost about $118.8 million in 2004, which would be fully covered by premium payments from participants.

The Buy-in could be extended to people at higher income levels as well. For example, the income limits under scenario #1 are set at 300 percent of the FPL for individuals and an average salary of $31,000 for small employers. Eliminating these income eligibility limits would result in enrollment of about 92,923 people (scenario #3).

Another alternative is to retain the income eligibility limits, but increase the firm size eligibility level from 25 or fewer workers to 50 or fewer workers as under scenario # 5 in ***Figure ES-1***. Under this scenario, buy-in enrollment grows to about 65,240 people, of whom about 8,741 would be currently uninsured people who would take coverage due to the Buy-in with about 56,499 currently insured people shifting to the Buy-in from commercial coverage.

Insurance Market Impacts

The VHAP Buy-in could dramatically reduce the number of people purchasing coverage in three important insurance markets in the state, which together cover about 133,200 Vermonters (***Figure ES-1***). These include the non-group market (17,718 people), association health plans (82,443 people), and the small group market (33,048 people). Under our first scenario, (i.e., with income limits; no waiting period; and firm size limit of 25 or fewer workers), we estimate that about 30 percent of those currently enrolled in these markets (39,971 people) would shift to the VHAP Buy-in to take advantage of the lower premium.

The Buy-in could be structured in ways that attract an even larger share of the commercially insured population. For example, increasing the firm size eligibility level from 25 or fewer workers to 50 or fewer workers (as in Scenario # 5) would attract about 42.4 percent (56,499

[1] Estimates provided by Ms. Karen Bender, Mercer Risk, Finance and Insurance, Milwaukee, WI.

Figure ES-1
Summary of the Impacts of the Buy-in Under Five Variations in Eligibility in 2004 [a/]

	Scenario # 1: With Income Limits; No Waiting Period; 25 or Fewer Workers	Scenario # 2: With Income Limits; With Waiting Period; 25 or Fewer Workers	Scenario # 3: Without Income Limits; No Waiting Period; 25 or Fewer Workers	Scenario # 4: Without Income Limits; With Waiting Period	Scenario # 5: With Income Limits; No Waiting Period; 50 or Fewer workers
Current Enrollment in Affected Markets (i.e., Non-Group, Small Group and Association Markets)					
Currently Insured in Affected Markets [b/]	133,209	133,209	133,209	133,209	133,209
People Eligible for Buy-in (Includes Currently Insured and Uninsured Who Qualify)					
Total Buy-in Eligible Population	91,076	52,298	154,214	65,506	108,076
People Who enroll in Buy-In					
Total Buy-in Enrollment	47,129	10,704	92,923	13,481	65,240
Uninsured Who Become Covered [c/]	7,158	7,158	9,612	9,612	8,741
Currently Insured who Shift to Buy-in (i.e., People in Affected Markets) [d/]	39,971	3,606	83,311	3,869	56,499
Percent of Affected Markets Shifting to Buy-in [e/]					
Percent of Non-group, Small Group and Association Enrollment Shifting to Buy-in	30.0%	2.7%	62.5%	2.9%	42.4%
Program Costs (millions)					
Total Program Costs [f/]	$118.8	$26.8	$235.7	$33.3	$164.4
Benefits Payments	$98.0	$22.1	$194.4	$27.5	$135.6
Administration	$20.8	$4.7	$41.3	$5.8	$28.8
Changes in Provider Reimbursement Levels (millions)					
Reductions in Provider Payments [g/]	$27.9	$2.5	$58.1	$2.7	$39.4
Reductions in Uncompensated Care	$5.3	$5.3	$7.1	$7.1	$6.5
Change in Cost-Shift [h/]	$15.2	($2.8)	$34.4	($3.0)	$22.2
Changes In Premium Costs Per Person for Buy-in Enrollees and Those Who Remain with Commercial Insurance					
Savings Per Buy-in Participant	$698	$694	$697	$710	$697
Increased Costs for Those who Remain with Commercial Insurance (per person)	$47	($8)	$124	($9)	$72
Initial Reserve Requirement (millions)					
Initial Reserve Requirement [i/]	$20.4	$5.5	$40.0	$6.9	$28.2

Figure ES-1 (Continued)
Summary of the Impacts of the Buy-in Under Five Variations in Eligibility in 2004 a/

a/ The scenarios with income limits (scenarios # 1, 2 and 5) assume that eligibility is limited to individuals with incomes below 300 percent of the FPL and/or workers and dependents in firms with an average payroll of less than $31,000 per worker.
b/ Includes people insured in: the non-group market (17,718 people); the small group market, which includes firms with 50 or fewer workers (33,048 people); and association health plans (82,443 people).
c/ The uninsured are assumed to enroll based upon studies of the impact that reductions in premiums have on the likelihood that employers and individuals will take coverage.
e/ Computed as the total number of currently insured people shifting to the Buy-in divided over the over the number of people currently enrolled in the non-group, small group and association insurance markets (133,209 people).
f/ Premiums are assumed to be set at the levels required to fully fund the program so that there is no net cost to the state. We estimate the premium for small groups (assuming $500 deductible) to be $235 for adults and $106 for children. For people purchasing coverage as individuals (assumes $3,000 deductible) the premium would be $207 for adults and $79 for children.
d/ Eligible individuals and groups are assumed to shift to the buy-in if the buy-in premium is less than what they currently pay for coverage.
g/ Reductions in provider payments for services provided to people who shift from commercial insurance to the buy-in.
h/ About 75 percent of the net changes in provider reimbursement and uncompensated care is assumed to be passed-on to people who continue to have commercial insurance in the form of higher charges, which is known as the cost-shift.
i/ Assumes initial reserve requirement equal to 2.5 months of claims for scenarios with over $50 million in expected claims and 3.0 months for scenarios with less than $50 million in expected claims costs.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

people) of people currently insured in these three markets. Alternatively, the income eligibility levels could be eliminated, as under scenario # 3, which would result in about 83,311 people shifting from commercial coverage to the Buy-in. This would be 62.5 percent of the people currently enrolled in these three insurance markets.

It is unclear whether the affected insurance markets would be viable with the loss of such a large portion of current enrollment. An enrollment loss of this magnitude could substantially reduce any economies of scale that exist in administering these insurance pools and greatly destabilize premiums by reducing the predictability of losses for such groups. This together with the increase in the cost-shift (discussed below) would increase private insurer premiums that could result in a loss of coverage among those who remain in the commercial markets.

Loss of such a large portion of the market to the Buy-in could result in the withdrawal of the few commercial insurers that remain in Vermont's individual and small group markets. For example, BISCHA data indicate that about 93.5 percent of people who are fully-insured (i.e., excluding people in self-funded plans) are concentrated among the four largest carriers in the state.[2] The loss of enrollment resulting from the Buy-in, could cause some of these remaining carriers to withdraw from the market. This is because the fewer people a carrier covers, the more difficult it is to justify the overhead costs involved in operating in the state, such as regulatory compliance and Marketing costs. Moreover, the prospect of competing for enrollment with a state plan that is able to undercut provider payments in this way could greatly discourage insurers from participating in Vermont insurance markets.

Cost Shifting

One of the greatest concerns with the shift from commercial insurance to the Buy-in is that it would increase cost-shifting. Cost-shifting is the process whereby health care providers recover shortfalls in payments under public programs and uncompensated care costs by increasing charges for services provided to commercially insured patients. The available evidence indicates that we can expect that up to 80 percent of increases in payment shortfalls under public programs would be passed-on to commercial payers in the form of higher charges. Thus, we can expect that most of the reduction in provider income resulting from people shifting from commercial coverage to the Buy-in would be passed-on to those who remain with commercial insurance in the form of higher charges.

For example, in scenario # 1 (i.e., with income limits; no waiting period; and firm size limit of 25), we estimate that about 85 percent of those who enroll in the VHAP Buy-in would be people who shift from commercial coverage (39,971 people). The reduction in provider payments for those who shift to the Buy-in would be about $27.9 million. This would be partially offset by a reduction in uncompensated care costs of $5.3 million for providers due to a decline in the number of uninsured people under this scenario (7,158 people). We estimate that roughly three-quarters of the net reduction in provider revenues (i.e., about $15.2 million) would be passed-on to commercially insured people in the form of higher charges (i.e., the cost shift).

[2] Includes BCBS of Vermont, MVP health plan, TVHP health plan, and Cigna. See: "Health Insurance Coverage Estimates for Vermont Residents, 1999-2002," BISHCA, July 10, 2003.

We estimate that savings for people who shift from commercial coverage to the Buy-in would average about $700 per participant per year (***Figure ES-1***). However, due to the cost-shift, premiums for those who continue with commercial coverage would increase by about $47 per person in 2004. This increase would apply to all commercially insured people including those in the non-group market, the small group market, association health plans, the large group market, and self-funded plans (currently 361,000 Vermonters). Thus, when the cost-shift is included, the Buy-in effectively reduces costs for a select group of privately insured people at the expense of others who remain with commercial insurance.

Minimizing Loss of Market Share

To avoid the shift of currently insured people to the Buy-in, eligibility could be limited to only those low-income people who are currently uninsured by requiring a 12 month waiting period before enrollment. For example, in scenario # 2, we assume that individuals are required to be uninsured for 12 months prior to enrolling in the program, and that small employers must not have offered insurance to their workers for the past 12 months to be eligible. Participation in the program would be limited to three years so that these individuals do not permanently escape the private markets and to further minimize the loss of market share.

Under this scenario, the number of people shifting from private coverage to the Buy-in would be reduced from 39,971 people under scenario # 1 (i.e., without a waiting period) to about 3,606 people with a waiting period requirement (***Figure ES-1***). These 3,606 people represent only about 2.7 percent of enrollment in the affected markets.

Not all of the variants of the Buy-in proposal would increase the cost-shift. For example, if we were to add a 12-month waiting period requirement, as under scenario # 2, the cost-shift is actually reversed. The reason for this is that the reduction in the uninsured population under this scenario (7,158 people) would reduce uncompensated care costs, while eliminating nearly all of the reduction in provider income that comes from allowing currently insured people to shift to the Buy-in. In fact, the cost-shift is actually reduced by a modest amount (i.e., about $2.8 million) if we enact the Buy-in with a waiting period requirement.

Initial Claims Reserves

As with any health insurance plan, the Buy-in program should have a claims reserve for unexpectedly high claims. The reserve is typically equal to an amount equal to between two months and three months of expected claims for the year. The reserve amount required at the inception of the program varies from $5.5 million to $40.0 million depending upon the eligibility scenario selected.

Conclusions

The VHAP Buy-in model could reduce the number of Vermonters without insurance by up to about 9,600 people, depending upon eligibility provisions. However, this is only about 15 percent of the 61,700 people in the state who are now without coverage. This is because even with the 25 percent reduction in provider payment rates, the premiums would continue to be unaffordable to many of the uninsured.

The program could result in a loss of insurers from the already ailing non-group and small group markets of Vermont, resulting in reduced access to coverage for those who are not eligible for the Buy-in. Premiums are also likely to increase in these insurance markets due to a loss of economies of scale in administration, an increase in cost-shifting and increased uncertainty in predicting benefits costs. Concerns over potential adverse selection in the commercial plans that remain could also discourage insurers from participating in the Vermont Insurance markets.

The migration of currently insured people to the Buy-in could be nearly eliminated by imposing a 12 month waiting period requirement on individuals and employers. This approach would avert a large scale shift of insured people to the Buy-in while actually reducing cost-shifting from uncompensated care for the uninsured who become covered. Participation could be limited to a maximum of three years so that these employers and individuals do not permanently escape the existing insurance markets. However, the fairness of this approach is unclear given that those who are already providing coverage would be bared from obtaining the same low-cost coverage available to otherwise identical employers.

A Buy-in to the Vermont Health Access Program (VHAP) for Individuals and Small Employers

The purpose of this analysis is to estimate the impact of a program that would permit low-income individuals and small employers with low-wage workers to enroll in the Vermont Health Access Program (VHAP) by paying a premium based upon the cost of providing this coverage under VHAP. For many individuals and employers this would be a lower-cost health insurance option primarily because VHAP provider payment levels are substantially lower than payments under commercial insurance. This lower-cost option is designed to expand health insurance coverage in Vermont.

In this paper, we summarize the features of the VHAP Buy-in proposal and present the assumptions that we used to simulate its impact. We also present our estimates of the cost and coverage impacts of implementing this approach under selected variations in eligibility criteria. In addition, we provide analyses of risk-selection behavior under the proposal assuming alternative rating regulations in the individual and small group health insurance markets of Vermont.

The analysis is presented in the following sections:

- Buy-in Description;
- Key assumptions;
- Cost and coverage impacts analysis;
- Reserve requirements;
- Selection effects under the buy-in;
- Alternative eligibility levels; and
- Conclusions.

A. VHAP Buy-in Description

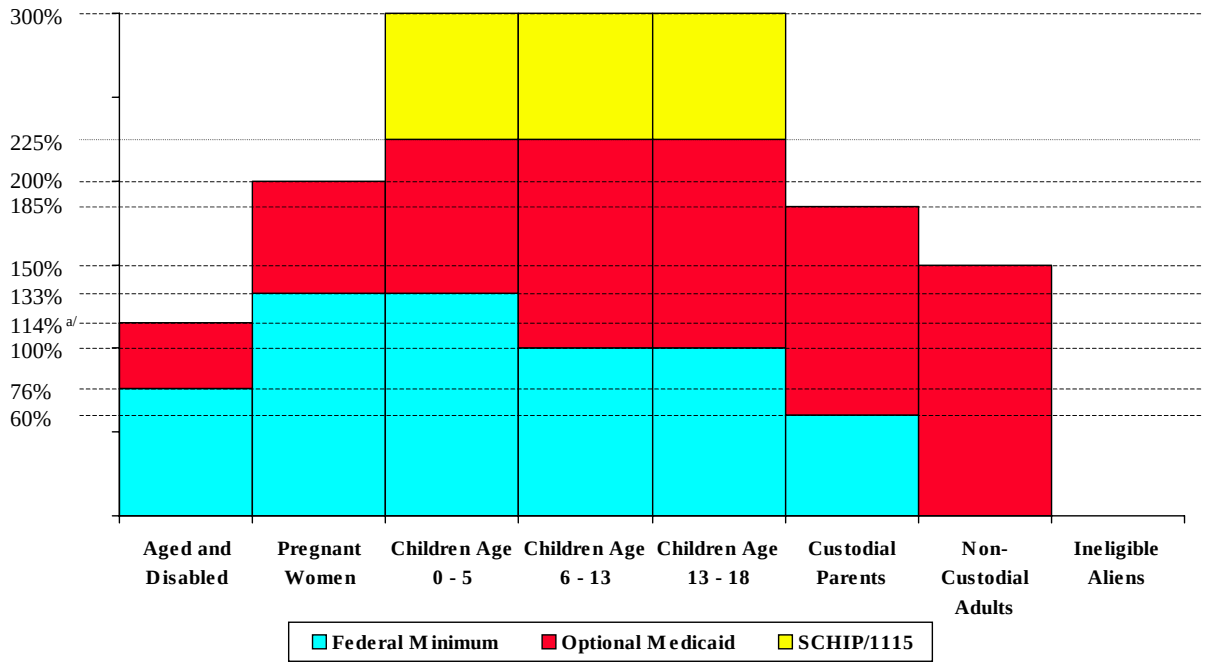
The objective of the VHAP Buy-in is to provide a lower-cost alternative to the private insurance now available to individuals and small employers in Vermont. The key features of the program that we have modeled is presented below, beginning with a description of the current VHAP program.

1. Current VHAP Program

The income eligibility levels under the Vermont VHAP program are among the highest in the country. As shown in ***Figure 1,*** Vermont has exercised options available to states to increase eligibility beyond the federal minimum eligibility levels. Aged and disabled people are covered through about 114 percent of the FPL compared with the federal minimum of 76 percent of the

FPL (92 percent of the FPL for married couples).[3] Pregnant women are covered through 200 percent of the FPL, and all children are eligible through 300 percent of the FPL.[4]

Figure 1
Summary of Income Eligibility Levels as a Percentage of the Poverty Level for Medicaid and SCHIP in Vermont



a/ The income eligibility level for aged and disabled people is equal to 114 percent of the FPL in Chittenden County and 105 percent of the FPL in the rest of the state.
Source: Lewin Group analysis of Vermont Medicaid and SCHIP programs.

The state has also expanded coverage for adults. For example, the state has exercised its option to increase the income eligibility level for custodial parents above the federal minimum (about 60 percent of the FPL in Vermont) to 185 percent of the FPL.[5] The state also covers non-custodial adults (i.e., adults who do not have custodial responsibilities for a child) through 150 percent of

[3] The income eligibility level for aged and disabled people is equal to 114 percent of the FPL in Chittenden County and 105 percent of the FPL in the rest of the state.
[4] All children are enrolled in the Dr. Dynasaur program. The standard federal matching rate applies to children though 225 percent of the FPL, while the SCHIP enhanced matching rate applies for children between 225 and 300 percent of the FPL.
[5] Under federal law, the state's income eligibility level for parents must be at least equal to the income eligibility level for families under the ADFC program which is known as the TANF income eligibility levels.

the FPL under an 1115a Medicaid waiver program. There are only six other states with an 1115a waiver to cover non-custodial adults.[6]

The state receives matching funds for non-custodial adults below 150 percent of the FPL because the state obtained a waiver to cover this group. Under the federal waiver process, states are permitted to extend coverage to categorically ineligible groups only if it is implemented as part of an overall program that is "budget neutral". Vermont was able to meet this revenue neutral requirement by also placing a large portion of the state's categorically eligible population in managed care programs that were projected to save enough to pay for the costs of covering non-custodial adults through 150 percent of the FPL.

2. Buy-in to VHAP for Employers and Individuals

The VHAP Buy-in program could be used to provide a lower-cost coverage alternative for individuals and employers. In this analysis, we analyzed the effect of permitting individuals without access to employer coverage living below 300 percent of the FPL to purchase coverage under the VHAP program by paying a premium. Similarly, small employers with low-wage workers could be given the option of purchasing coverage for their employees and dependents through VHAP.

The benefits provided under the "Buy-in" option would be a based upon the Blue Care Options Plus A insurance product offered by Blue Cross/Blue Shield of Vermont. However, provider payment levels per unit of service would be equal to 110 percent of Medicare payment rates for comparable services. Buy-in participants would be required to pay a premium equal to the full cost of their coverage (i.e., average cost per enrollee).

The eligibility criteria that we assumed for this analysis is as follows:

- Low-Income Individuals:
    - — People living below 300 percent of the FPL;
    - — Without access to employer based coverage; and
    - — No waiting period since last insured.
- Small Employers:
    - — Firm with 25 or fewer workers;
    - — Average worker salary below the average for small employers in the state (about $31,000);
    - — Employer must pay half of the premium;
    - — 75 percent of eligible workers must enroll; and
    - — No waiting period since last offered coverage.

[6] There are eight states with an 1115 waiver to cover non-custodial adults including; Vermont, New York, Tennessee, Massachusetts, Oregon, Hawaii, Delaware, and Arizona. In addition, Minnesota and Washington cover non-custodial adults under a state-only program (i.e., no federal matching funds).

A key assumption here is that there is no waiting period requirement since last insured.[7] This means that people currently purchasing insurance in the individual market would be permitted to discontinue their current private coverage and enroll in the Buy-in. Similarly, eligible small employers who are already providing coverage would be permitted to discontinue their private coverage and shift their workforce to the program.

We also estimated eligibility, enrollment and costs under alternative eligibility criteria. For individuals, we varied the income eligibility levels with and without requiring a waiting period since last insured (e.g., 12 months). We also simulated eligibility and enrollment for firms with under 25 workers under alternative requirements such as a waiting period and the average employee wage level required for eligibility.

3. VHAP Buy-in Provider Payment Levels

Although participants would be required to pay the full premium for coverage, the premium is still likely to be lower than the cost of purchasing comparable coverage in the private sector. This is because provider payment levels under the Buy-in are assumed to be equal to about 110 percent of Medicare payment levels, which is substantially lower than payment levels under commercial plans.

Based upon data provided by the Department of Banking, Insurance, Securities and Health Care (BISHCA), payments to hospitals under Medicare are equal to 94.0 percent of costs, meaning that 110 percent of the Medicare payment levels would be about 103.4 percent of costs (***Figure 2***). This compares with hospital payment rates for commercial insurance equal to about 134.7 percent of costs.

Figure 2
Hospital Payment-to-Cost Ratios, 2001

State	Payment-to-Cost Percentage
Medicaid	81.8%
Medicare	94.0%
110 Percent of Medicare	103.4%
Commercial	134.7%

Source: Estimates obtained from the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA).

Physician payment rates in commercial insurance are equal to about 150 percent of Medicare payment levels, which means that at 110 percent of Medicare rates, physicians payments under the Buy-in would be equal to about 73 percent of commercial rates.[8] In addition, administrative costs under the Buy-in would be slightly lower than under the Blue Care product because of

[7] The waiting period since last insured should not be confused with the waiting period for pre-existing conditions which is assumed to remain the same as under current law.
[8] Estimate provided by Ms. Karen Bender, Mercer Risk, Finance and Insurance, Milwaukee, WI.

lower marketing costs (i.e., elimination of commission payments to brokers and agents, reduced allowances for insurer profits).

4. VHAP Buy-in Benefits

Covered services under the program are assumed to be the same as under the Blue Care Options Plus A program sponsored by Blue Cross and Blue Shield of Vermont. This includes inpatient and outpatient hospital care, emergency care, ambulance services, physician office visits, specialist office visits, prescription drugs and ambulance services. The Blue Care Options Plus A program is a PPO with higher cost sharing for out-of-network utilization. However, the Blue Care benefits package would be modified to use a different set of cost sharing parameters.

The benefits package offered to small employer groups would have a $500 deductible while the package offered in the individual market would have a deductible of $3,000. All other cost sharing would be the same for both small groups and individuals. We also assume that there would be no distinction between in-network and out-of-network services. The cost sharing parameters for the Blue Care Options Plus A product and the VHAP Buy-in program are presented in ***Figure 3.***

Figure 3
Coinsurance Under VHAP Buy-in Blue Care Options Plus-A Compared

Covered Services	Blue Care Options Plus A	VHAP Buy-in: Small Group	VHAP Buy-in: Individuals
Co-payments			
PCP and Gyn. Office Visit Co-pay	$10	$20	$20
Specialist Office Visit Co-pay	$20	$20	$20
Inpatient Co-pay	none	none	none
Outpatient Co-pay	none	none	none
Ambulance Co-pay	none	none	none
Emergency Room Co-pay	$50	$50	$50
Out of Network Co-insurance	70%	NA	NA
Deductibles			
Hospital Deductible	none	$200	$200
In-network Deductible	none	$500	$3,000
Out-of-network Deductible	$500	NA	NA
Prescription Drugs	none	$100	$100
Prescription Drug Co-pays			
Generics	$10	40%	40%
Preferred	$15	50%	50%
Non-Preferred	$30	60%	60%
Maximum Drug Benefit			
Out-of-pocket Limit			
In-network	NA	none	none
Out-of-network	$3,000	NA	NA

B. Key Assumptions

The estimates presented in this report were developed using The Lewin Group Health Benefits Simulation Model (HBSM), which was adapted for use in Vermont. The model is based upon a

survey of households that provides extensive information on sources of insurance and health spending called the 1996 Medical Expenditures Panel Survey (MEPS) data. The model is controlled to replicate coverage and health spending data developed by the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), Vermont Division of Health Care Administration. The model was used to simulate the Buy-in program based upon studies of individual and employer sensitivity to changes in the price of insurance.

Our key assumptions are presented in the following sections:

- Model overview;
- Buy-in premiums;
- Individuals buying into VHAP;
- Employers buying into VHAP;
- Utilization Effects; and
- Cost-shifting.

1. Model Overview

The HBSM is a micro-simulation model of the U.S. health care system that is designed to simulate policies ranging from narrowly defined Medicaid coverage expansions to broad-based reforms such as changes in the tax treatment of health benefits. We adapted the model for simulating the impact of health reform options for the state of Vermont. We did this by benchmarking the coverage data from the Vermont Family Health Insurance Survey developed by BISHCA. We also used health spending data provided by BISHCA and the VHAP program.

The key to the model's design is a "base case" scenario depicting the distribution of health services utilization and expenditures across a representative sample of households under current policies for a base year, which in this study is 2004. The primary database used in the model is the 1996 MEPS data developed by the Agency for Healthcare Research and Quality (AHRQ).[9] These data provide information on sources of insurance coverage, health spending and demographic characteristics for a representative sample of households nationally. We adjusted these data to reflect the recent BISHCA survey of families. In Vermont showing the distribution of people in the state by source of insurance coverage and other demographic characteristics.[10] The model also uses as input a recent survey of employers conducted by the Kaiser Family Foundation and the Health Research and Education Trust (HRET), which provides information on employer characteristics and health plan provisions.[11]

[9] MEPS is sponsored by the Agency for Health Care Policy and Research. For more information about MEPS, see J. Cohen et al. , "The Medical Expenditure Panel Survey: a national health information resource" *Inquiry*. 1996-97 Winter; 33(4):373-89.

[10] "Counting What Counts: Health Insurance Coverage in Vermont, First Findings from the 2000 Vermont Family Health Insurance Survey", Vermont Department of Banking, Insurance, Securities and Health Care Administration, Vermont Division of Health Care Administration, July 2001.

[11] L. Levitt, J. Gabel, et al. Employer Health Benefits 1999 Annual Survey. The Henry J. Kaiser Family Foundation and Health Research and Educational Trust (HRET), 2000.

The health expenditure data in the database were also adjusted to reflect estimates of health expenditures in the state by type of service and source of payment as estimated by BISHCA for 2001 that we projected to 2004.[12] We developed these estimates based upon projections of the growth in health spending by type of service developed by the Office of the Actuary of the Centers for Medicare and Medicaid services.[13] These projections were adjusted to reflect the fact that health spending in Vermont has been growing faster than the national average in recent years.

The model simulates enrollment in voluntary programs such as the Buy-in for individuals and employers, based upon multivariate models of how coverage levels for these groups vary with changes in the cost of coverage, which we define as the difference between the VHAP premium and the premium they now face in the Vermont health insurance markets. In addition, the model simulates enrollment in Medicaid or SCHIP expansions based upon a multivariate analysis of historical take-up rates under these programs, including a simulation of the substitution of public for private coverage under these proposals (i.e., "crowd out").

2. VHAP Buy-in Premium

As discussed above, we assume that the VHAP Buy-in benefits package would be based upon the Blue Care Options-Plus A product offered by BCBS of Vermont. The average premium for single coverage under the BCBS product in 2004 for small groups is about $383 per person per month (PMPM) for adults and $185 PMPM (Lewin Group Estimate) for children (***Figure 4***). We estimated the corresponding premiums for non-group coverage based upon differences in the age composition of Vermonters with non-group coverage as compared with the age composition of the small group population. Based upon these adjustments, we estimate that the premium for this product in the non-group population would be $427 PMPM for adults and $173 PMPM for children.

We assume that the cost-sharing for the VHAP Buy-in would differ from that of the Blue Care Options Plus A product in several ways. While the BCBS product has no deductible (for in-network care), the Buy-in would have a deductible of $500 for small groups ($3,000 in the Non-Group market) for individuals and would have a $200 deductible on inpatient hospital care and a $100 deductible for prescription drugs (***Figure 3*** above). There would also be differences in co-payments for services and drugs. We estimated the impact of the change in cost-sharing based upon an actuarial analysis of premiums under these benefits packages using the Tillinghast database.[14] The effect on premiums is shown in ***Figure 4***

[12] "Vermont Health Care Expenditure Analysis, 2001", The Department of Banking, Insurance, Securities and Health Care Administration, Vermont Division of Health Care Administration, March 2003.
[13] Stephen Heffler, et al., "Health Spending Projections for 2001-2011: The Latest Outlook," *Health Affairs*, vol. 21, no. 2, (March/April) 2002.
[14] Tillinghast HealthMAPS 2003 Medical Rate Manual and Software, distributed January 2003 by Tillinghast - Towers Perrin, St. Louis, MO.

Figure 4
Derivation of Monthly Premium Estimates for VHAP Buy-in in 2004

	Adults in the Small Employer Groups: $500 Deductible		Adults in the Individual Market: $3,000 Deductible		Children in the Small Employer Groups: $500 Deductible		Children in Individual Market: $3,000 Deductible	
Blue Care Options Plus A		**$383** [a/]		**$427** [b/]		**$185** [a/]		**$173** [b/]
Estimated Administration	$57		$64		$28		$26	
Pure Premium (i.e., benefits, costs)	$326		$363		$157		$147	
Change in Pure Premium		**-$120**		**-$188**		**-$65**		**-$81**
Pure Premium	$326		$363		$157		$147	
Changes in Cost Sharing	-54		-$135		-$38		-$62	
Changes in Payment Levels								
Hospital [c/]	-$28		-$20		-$10		-$7	
Physician/Other Providers [d/]	-$31		-$22		-$11		-$8	
Prescription Drug Rebate [e/]	-$7		-$11		-$6		-$4	
Change in Administrative Cost		**-$28**		**-$32**		**-$14**		**-$13**
BC/BS Administration	$57		$64		$28		$26	
VHAP Buy-in Administration [f/]	$29		$32		$14		$13	
VHAP Buy-in Premium in 2001		**$235**		**$207**		**$106**		**$79**
Administrative Cost	$29		$32		$14		$13	
Pure Premium	$206		$175		$92		$66	

a/ Blue Care Options Plus A, premium in 2004 is $383 for adults, of which about 15 percent is attributed to retention. Premium for children in the small employer groups is assumed to be about 48 percent of the adult premium, based upon HBSM estimates of per capita employer costs for children in Vermont.
b/ Premiums are adjusted for differences in the age composition of the non-group population. Non-group costs are 11.5 percent greater than small groups for adults but about 6.2 percent lower than small group for children.
c/ Payment rates for hospital services would be about 23 percent less than commercial rates. Hospital services comprise about 46 percent of benefits in the small employer groups and about 40 percent of payments in the non-group market.
d/ Payment rates for physician and other medical professional services would be about 27 percent less than commercial rates under the buy-in. These services comprise about 42 percent of costs for small employer groups and about 38 percent of costs in the individual market.
e/ Payment Rates for drugs are assumed to be 21 percent lower than commercial payments. Drugs comprise about 12 percent of costs.
f/ Estimate based on analysis of how the Buy-in would affect the various components of administrative costs including: marketing costs; claims processing costs; general administrative costs; and allowance for profits. This results in administrative costs equaling about 14 percent of claims costs in the small group market and about 18 percent of claims costs in the individual market.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM) and Tillighast data .

In addition, the VHAP Buy-in would reimburse providers at about 110 percent of Medicare provider reimbursement levels. The program is also assumed to receive the same prescription drug rebates now received by Vermont Medicaid (about 21 percent).[15] These reimbursement levels are lower than under the BCBS product by about 23 percent for hospitals, 27 percent for physicians and 21 percent for drugs. Thus, premium levels under the Buy-in would be lower than the price of comparable private health insurance.

We estimated administrative costs based upon an evaluation of the impact that the Buy-in would have individual components of administrative costs including: marketing costs, claims processing costs, general administration and allowance for profits. We assume that administrative costs under the program would be comparable to large groups for all categories of administration except general administrative costs. This reflects the fact that the Buy-in is expected to enroll over 10,000 people in a plan with uniform benefits, without broker/agent commissions, and a reduced allowance for profit. However, general administrative costs in the VHAP Buy-in are assumed to be the same as under the current BCBS product because the enrollment and premium collection costs are expected to be similar to those for small group and individual coverage. This results in administrative costs equaling about 14 percent of claims costs in the small group market and about 18 percent of claims costs in the individual market.

Using these payment levels and administrative cost assumptions, we estimate that the Buy-in premium for the benefits package described above for small employer groups would be about $235 PMPM for adults and about $106 PMPM for children (***Figure 4).*** This premium would apply to both Premiums in the non-group market, which assumes a deductible of $3,000, would be $207 PMPM for adults and $79 PMPM for children.

In ***Figure 5***, we compare our estimates for the VHAP Buy-in premium with those developed by Mercer for this project. This comparison is interesting because Mercer built-up their premiums based largely on VHAP data while we estimate the premium starting with a private insurance product. The estimates are quite similar.

Figure 5
Estimated VHAP Buy-in Premiums PMPM Compared for 2004

State	Small Employer Groups: $500 Deductible	Individual Market: $3,000 Deductible
The Lewin Group		
Adults	$235	$207
Children	$106	$79
Mercer		
Adults	$230	$204
Children	NE	$76

Source: The Lewin Group and Karen Bender, Mercer Finance & Insurance, December 2003.

[15] Based upon CMS 64 data for the Vermont Medicaid program.

Figure 6
Estimated Buy-in Premiums Under Alternative Reimbursement Rate Assumptions Under selected Deductibles

	VHAP Reimbursement Levels		110% of Medicare Reimbursement Levels		Commercial Reimbursement Levels	
	$500 Deductible	$3,000 Deductible	$500 Deductible	$3,000 Deductible	$500 Deductible	$3,000 Deductible
Small-group Market						
Adults	$177.17	$139.79	$229.73	$186.07	$297.02	$241.75
Non-group Market						
Adults	$181.76	$144.40	$249.90	$204.51	$329.42	$280.22
Children	$77.28	$51.99	$108.20	$76.33	$142.05	$105.23

Source: Karen Bender, Mercer Finance and Insurance, December 2003.

3. Individuals Buying into VHAP

The VHAP Buy-in has the effect of providing individuals with a lower-cost alternative to the coverage available in the non-group market. In this analysis, we conceptualize this as a reduction in the price of insurance. We simulated the impact that this would have on coverage using a multivariate model of how the likelihood of an individual purchasing coverage changes as the price of coverage (i.e., the premium) is reduced. This model shows an average price elasticity for coverage of –0.34 (i.e., a 1.0 percent decrease in premiums is associated with an increase in coverage of about 0.34 percent).

However, the impact of changes in premiums on coverage varies with the income and demographic characteristics of affected persons. For example, the price elasticity varies from about –0.31 among people with family incomes of $50,000 to –0.55 among those with incomes of $10,000. Thus, the price response tends to be higher for lower-income people than for higher-income people. The estimated price elasticity varies from about -0.46 for people age 20 to -0.30 for people age 60, meaning that younger people are more sensitive to changes in premiums than are older people.

The model was used to estimate the premium faced by each uninsured individual/family in the individual market, and the amount of the credit that eligible people would receive. Eligible individuals were then randomly selected to become covered based upon the change in the net cost of insurance to the individual as a result of the program (i.e., private premium less Buy-in premium) and the price elasticity assumptions discussed above.

As discussed above, under the Buy-in program modeled here we have assumed that individuals who are currently purchasing insurance in the non-group market would be permitted to drop that coverage to enroll in the VHAP Buy-in. We assume that all eligible people do so in cases where the VHAP Buy-in premium is less than what they are now paying for coverage. We also present coverage and cost estimates under a scenario where individuals are required to have been uninsured for at least 12 months (i.e., a waiting period), to limit the migration from commercial insurance to the Buy-in.

4. Employer Decision to Buy-in to VHAP

The number of employers offering coverage is assumed to increase in response to the availability of the VHAP Buy-in options. We have simulated the impact of the Buy-in as a lower-cost coverage option that could stimulate some non-insuring employers to offer coverage. We assume that employers would see the program as a reduction in the price of insurance in cases where the Buy-in premium is less than what they would need to pay for comparable coverage in the private market.

We simulated the impact that this would have on the number of employers sponsoring coverage based upon a Lewin Group multivariate analysis of the relationship between premiums and the likelihood of providing coverage, which is based upon the 1997 survey of employers sponsored by the Robert Wood Johnson Foundation (RWJF). These analyses show employer price elasticity estimates ranging from –1.5 for firms with under 10 workers to -0.21 for firms with over 1,000 workers.[16]

We simulate this take-up in coverage in the following steps:

- For each non-insuring firm in the model, we estimated the cost of coverage in the current market, which reflects the community rating rules requirements in Vermont for insuring employers in the small group market, and the rating rules that apply in Association health plans;

- We then calculated the premium for the group under the proposal based upon the Buy-in premium amount;

- Firms are randomly selected to enroll based upon the change in the price for coverage and the price elasticity estimates described above;

- The portion of the premium paid by the employer is estimated for every firm that is simulated to offer coverage based upon a multivariate analysis of employer contribution levels as reported in the 1997 RWJF data which we have adjusted to reflect Vermont specific employer coverage data from the employer survey component of the 1996 MEPS data;

- Workers who are offered coverage in these newly insuring firms are selected to enroll based upon a multivariate analysis of MEPS data on employee take-up rates in employer-sponsored plans by worker characteristics and employee contribution requirement (take-up rates averaging about 95 percent).

As discussed above, we assume that eligible firms that now offer coverage would be permitted to discontinue that coverage and shift to the VHAP Buy-in program. In these cases, we assume that the employer would discontinue their current coverage and cover their workers under the Buy-in if the Buy-in premium is less than what they are now paying for coverage. However,

[16] For example, in a firm with 10 or fewer employees, a reduction in the price of insurance of 1.0 percent is associated with an increase of 1.5 percent in the number of firms offering coverage.

estimates of enrollment and costs are presented below under a variant of the Buy-in where firms can not enroll unless they have not offered insurance in the past 12 months.

5. Utilization Response

We assume that uninsured children who become covered under the proposal would use health care services at the same rate reported by currently insured children with similar age, sex and health status characteristics. This assumption encompasses two important effects. First, the increase in access to primary care for this population would result in savings due to a reduction in preventable emergency room visits and hospitalizations. Second, there would be a general increase in the use of elective services such as primary care, corrective orthopedic surgery, advanced diagnostic tests, and other care that the uninsured often either forego or delay. Using this methodology, we estimate that health spending among the currently uninsured population would increase. That is, savings from improved primary care would be more than offset by increased use of elective care.

6. Payment Levels and Cost Shifting

As discussed above, provider reimbursement levels under the Buy-in would be at Medicare levels. This would represent a reduction in reimbursement for services provided to currently insured people who shift from private health plans to the VHAP program of 20 percent or more. We estimated these changes in provider revenues based upon the figures presented above on the relationship between payment levels under VHAP and private payers. We also estimated the reduction in provider uncompensated care, which would partially offset the reduction in provider reimbursement.

These changes in reimbursement are expected to affect provider cost-shifting in the state. Cost shifting is the process whereby providers recover the cost of reimbursement shortfalls under public programs and uncompensated care through higher charges to private payers. We simulated the impact of the changes in provider income under the VHAP Buy-in based upon studies of historical data on provider cost-shifting in response to the cost-shift.

An analysis of historical data on hospital cost-shifting indicates that about 40 percent of reductions in public program payments and uncompensated care are ultimately passed back to private payers in the form of higher charges for health services. The evidence for other providers (i.e., physicians and other health professionals) indicates that about 20 percent of reductions in public program reimbursement and increases in free care expenses are negotiated back to payers in the form of higher charges.[17]

However, these estimates are based upon analyses of system-wide cost-shifting effects nationally and in California where there is extensive competition among providers, which limits the provider's ability to simply increase prices. This differs from Vermont where there is little competition between hospitals and many physicians are often the only doctor within several miles. Thus, providers in Vermont are better able to pass-on reductions in provider payments

[17] Rice, Thomas, et al., "Physician Response to Medicare Payment Reductions: Impacts on public and Private Sectors," Robert Wood Johnson Grant No. 20038, September 1994.

due to the Buy-in than in other states. For purposes of this analysis, we assume that 80 percent of reductions in hospital reimbursement and 70 percent of payment reductions for physicians are passed-on to other payers in the form of higher charges.

C. Program Impacts

In this section, we present estimates of the cost and coverage impacts of the Buy-in program described above. This includes an analysis of program coverage and costs under the program and under variations in key eligibility rules. We also estimate the impact of the program on coverage under private insurance and health spending by employers, households and governments in 2004. Estimates for 2004 are useful for comparing program impacts at current levels of premiums, health expenditures and numbers of people without insurance. However, the earliest date of actual implementation would be at least six months after enactment and would require an initial investment in systems for administering the program.

Our results are presented in the following sections:

- Enrollment and costs under the Buy-in;
- Sources of coverage;
- Impact on state-wide health expenditures;
- Impact on state government spending in Vermont;
- Impact on federal health spending;
- Employer impacts; and
- Impact on household health spending.

1. Enrollment and Costs Under the VHAP Buy-in Proposal

As discussed above, we assume that the Buy-in is available to: individuals without access to employer coverage with incomes below 300 percent of the FPL; and small employers (less than 25 workers) with an average payroll of less than $31,000 per worker. Under this scenario, eligible individuals and employers are permitted to enroll in VHAP even if they are currently covered under commercial insurance.

We estimate that there are about 91,076 people who would be eligible. This includes all income eligible individuals and workers and dependents in firms with 25 or fewer employers with an average payroll below $31,000 per worker. Eligible employers includes firms currently purchasing insurance in the small group market and firms with association health plans that meet the income and firm size eligibility criteria.

Of these eligible people, about 47,129 people would enroll under the program. These include about 12,615 people purchasing coverage as an individual and about 34,514 workers and dependents who would be enrolled through a participating employer. Of the 47,129 who would enroll, about 7,158 would be people who would have been uninsured in the absence of the program (***Figure 7***). The remaining 39,971 people would be individuals who discontinue their commercial coverage (i.e., non-group, small employer market and association health plans) to enroll in the program.

Figure 7
Enrollment and Costs Under a Buy-in for Employers and Individuals in 2004 under Alternative Eligibility Scenarios [a/]

	Newly Enrolled People	Newly Insured People	Benefits Costs (in millions)	Premium Revenues [b/] (in millions)	Net Program Cost (in millions)
With Income Limits; No Waiting Period					
Employer Groups	34,514	3,967	$90.6	$90.6	$0.0
Individuals	12,615	3,191	$28.2	$28.2	$0.0
Both Employer Groups and Individuals	47,129	7,158	$118.8	$118.8	$0.0

a/ The Buy-in is simulated based upon the benefits package discussed above in ***Figure 3***. We estimate a premium for adults of $235 for small employer groups and $207 in the individual market. Assumes full phase in of enrollment in 2004.
b/Assumes premiums are adjusted to equal total program costs if necessary.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

By design, the Buy-in program would be self-financing. This is because the premium for the program is set equal to average costs per enrollee under the program. Total premium payments under this scenario would be $118.8 million in 2004, which would be roughly equal to projected program costs. However, enrollment is expected to grow gradually over time as eligible people learn about the program. We estimate that it could take up to two years before the program reaches the levels of enrollment shown in ***Figure 7***.

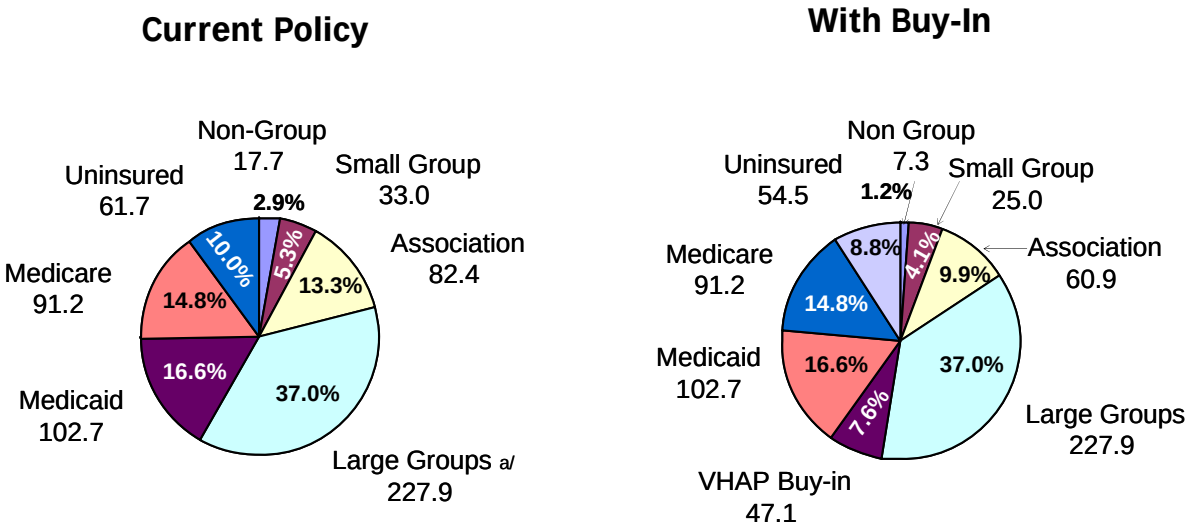
Estimates of Buy-in enrollment and cost impacts are discussed latter in this report.

2. Impact on Sources of Insurance

BISHCA estimates that there were 61,700 uninsured people in Vermont in 2002. This is about 10 percent of all Vermont residents (i.e., 616,600 people). About 14.8 percent of the population is covered under Medicare and about 16.6 percent are covered under Medicaid (***Figure 8***). The remaining 58.6 percent (361,000 people) are covered under some form of commercial insurance. The commercially insured population can be broken into four groups. Based upon BISHCA insurer data, only about 2.9 percent of the population (17,700 people) are covered under non-group health plans. About 5.8 percent (33,000 people) are in the small group market which is defined to include firms with 50 or fewer workers that are not covered under Association health plans. About 13.3 percent of Vermonters are covered under Association Health Plans (82,400 people), which is believed to include primarily firms with 50 or fewer workers.

Figure 8 shows the distribution of Vermonters by source of coverage under the Buy-in program described above as scenario # 1 (i.e., low income individuals small employers with low wage workers). As discussed above, we estimate that about 47,200 people would enroll in the Buy-in program. About 7,200 of these enrollees would uninsured people who either enroll in the buy-in as individuals, or as workers or dependents of firms that decide to offer coverage due to the availability of the Buy-in. The remaining 40,000 enrollees would be income eligible individuals and workers and dependents in eligible small firms that discontinue their commercial coverage to enroll in the Buy-in.

Figure 8
Source of Health Insurance for All Vermont Residents With and Without the Buy-in [a/]
(thousands)



Total Population = 616,592

a/ Assumed a VHAP Buy-in program for Individuals with incomes below 300 percent of the FPL and firms with 25 or fewer workers with average salary per worker below $31,000 (i.e., average salary in small firms in Vermont).
Source: Vermont Division of Health Care Administration, BISHCA 2000 VT Family Health Insurance Survey; Lewin Groups Simulations.

Figure 9 summarizes the shifts in coverage that take place under the Buy-in. Of the 33,000 people in the small group market (50 or fewer workers), about 25 percent (7,990 people) would discontinue their commercial coverage and move to the Buy-in. In addition, about 25 percent of those in association plans (21,500 people) would shift to the Buy-in and about 53 percent of those with non-group coverage (9,400 people) would shift to the program.

These estimates assume that existing forms of insurance in the non-group, small group and association markets would continue to exist to cover those who do not enroll in the Buy-in. However, it is unclear whether these sources of coverage would remain viable after loosing this much market share. In fact, it is unclear whether the few remaining insurers in these markets would find it cost effective to continue operating in the state for such a small number of people. Increased provider cost-shifting (discussed below) due to the lower payment rates under the Buy-in could also make it extremely difficult to justify remaining in such a market, particularly when they consider the cost of complying with Vermont insurer regulations. The question of the continued viability of the Vermont insurance market with the buy-in is discussed below.

Figure 9
Shifts in Source of Coverage under Buy-in

	Current Small Group/Individual Markets	Move to VHAP	Remain in Commercial Insurance Market
Currently Insured			
Non-Group	17,718	9,242	8,294
Small Group	33,048	7,991	25,057
Association	82,443	21,525	60,918
Total Insured	135,791	38,940	96,851
Uninsured Who Become Covered			
Non-Group	--	3,191	--
Employer	--	3,967	--
Total	135,791	47,129	96,851

Source: Lewin Group estimates using the Health Benefits Simulation Model

3. Impact on State-Wide Health Expenditures

We estimate that total health expenditures in Vermont would reach about $3.1 billion in 2004. This includes all health expenditures for Vermont residents paid by all public and private payers in the state. We estimate that state-wide health expenditures would increase by about $2.0 million under the Buy-in proposal. Payments for health services would increase by about $7.5 million due primarily to increased utilization for newly insured people. Administrative costs would be reduced by about $5.5 million as privately insured people are shifted to the VHAP Buy-in, where administrative costs would be lower than for commercial insurance (***Figure 10***).

Figure 10
Changes in State-Wide Health Spending Under the VHAP Buy-in Proposal in 2004
(in millions)

Change in Health Services Expenditures			**$7.5**
Change in utilization for newly insured		$12.2	
Change in utilization due to improved coverage		$2.7	
Net Change in Provider Reimbursement		($7.4)	
Net Change in Payment Levels	($27.9)		
Payments for uncompensated care	$5.3		
Increased cost shifting	$15.2		
Change in Administrative Costs			**($5.5)**
Insurer/Program Administration		$20.8	
Private Insurance Administration		($26.3)	
Total Change in Health Spending			**$2.0**

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Utilization of health services would increase by about $12.1 million for newly insured people. There would also be an increase in health services utilization of about $3.9 million among insured people whose coverage is improved when they move from private coverage to the Buy-in. This would include primarily increased prescription drug utilization for people shifting from

non-groups health plans that typically do not cover no prescription drugs, to the Buy-in program which does cover drugs.

These increases in spending would be more than offset by reductions in reimbursement levels under the program. As discussed above, payment rates under the VHAP Buy-in program on average would be about 25 percent less than provider payment rates under commercial insurance. Provider income would be reduced by about $27.9 million as privately insured people shift to the Buy-in program. This loss of provider income would be partially offset by a $5.3 million reduction in uncompensated care as many of the uninsured obtain coverage.

This results in a net reduction in provider income of about $22.6 million (i.e., $27.9 million - $5.3 million). As discussed above, we assume that 80 percent of the reduction in reimbursement to hospitals and 70 percent of the reduction in physician payments would be shifted to those who continue to be insured in the private market.[18] This is an increase in the cost-shift of about $15.2 million for a net reduction in provider reimbursement of $7.4 million (i.e., $22.6 million - $15.2 million in cost shift). This revenue loss is largely offset by the increase in utilization of about $14.9 million for a net increase in provider income of $7.5 million (i.e., $14.9 million - $7.4 million).

As discussed below, the cost of administering benefits for Buy-in enrollees would be about $20.8 million. This would be more than offset by a reduction in administrative costs for commercial insurance of about $26.3 million as people shift from commercial insurance to the VHAP Buy-in. This would result in a net savings in administration of about $5.5 million, reflecting the fact that the Buy-in would have lower administrative costs due to the elimination of broker and agent commissions, reduced allowance for profit, and the use of a single standardized benefits package.

Figure 11 summarizes how these changes in spending are distributed over major stakeholder groups. Because the Buy-in is designed to be self-funded, there would be little net change in state government health spending under the program, except to the extent that the increased cost-shift is reflected in state employee health benefits costs. Household spending for premiums and out-of-pocket spending increase by about $2.7 million due to increases in the number of people purchasing health insurance. Employer health spending would be reduced by about $3.7 million due to increases in the number of employers offering insurance.

However, economic theory and evidence indicate that wages would adjust over time to reflect the reductions in employer health benefits expenditures. This would result in a increase in wages for workers with employers who save under the Buy-in, and a reduction in wages for workers in firms where the employer decides to offer coverage as a result of the Buy-in. When these after-tax wage effects are counted, there is a net increase in wages of about $3.7 million (i.e., reductions in wages for newly insured people are less than the increases in wages for people in firms that save by shifting to the Buy-in). These changes in spending by stakeholder groups are discussed in greater detail below.

[18] We assume no cost-shifting associated with the savings for prescription drugs due to manufacturer rebates under the program, which are assumed to be 21 percent as under the current Medicaid program in Vermont.

Figure 11
Change in Health Spending by Stakeholder Group in 2004
(in billions)

	Without Wage Effects	With Wage Effects
Federal Government	$0.6	$0.3
State and Local Government	$2.4	$2.4
Private Employers	($3.7)	--
Households	$2.7	($0.7)
Total Health Spending	**$2.0**	**$2.0**

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

4. Impact on State Government Health Spending

We estimate that state and local government health spending would increase by about $2.4 million under the program (***Figure 12***). The Buy-in premiums would be set at the levels required to fully fund the program, resulting in no net change in costs to the Vermont state government. The program would cost about $118.8 million in 2004, including $98.0 million in benefits payments and about $20.8 million in administrative costs. Total premium revenues would be about $118.8 million, which is equal to the total cost of the program including benefits and administration.

However, costs in the state employees health benefits program would increase by about $2.6 million due to increased provider cost-shifting as a result of the Buy-in. This would be partially offset with savings of about $0.2 million in other state and local government programs serving the uninsured. We estimate little change in tax revenues due to the wage effects for private employers. Thus, state and local government spending would increase by about $2.4 million, primarily due to increased cost-shifting.

Figure 12
Change in Health Spending for State and Local Governments Under the Buy-in Proposal (in millions)

	Change in Spending
VHAP Buy-in **Program Benefits $98.0** **Administration $20.8** **Premium Revenues $118.8**	--
Cost-Shift to Public Employee Benefits Plans	$2.6
Other Government Programs	($0.2)
Tax Revenue change From Wage Effect (counted as an offset to state spending)	$0.0 [a/]
Net Cost (Savings)	**$2.4**

a/ Net change of less than $100,000.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

5. Federal Expenditures

There would also be an increase in spending for federal employee health benefits in Vermont of about $0.6 million due to the cost-shift. This would be partly offset by an increase in tax revenues of about $0.3 million attributed to the net increase in wages resulting from the Buy-in program. Thus, the program would result in a net increase in federal health spending in Vermont of about $0.3 million in 2004, primarily due to increased cost-shifting (***Figure 13***).

Figure 13
Change in Federal Health Spending
Under the VHAP Buy-in
(in millions)

	Change in Spending
Cost-Shift to Public Employee Benefits Plans	$0.6
Tax Revenue gain From Wage Effect (counted as an offset to federal spending)	($0.3)
Net Cost (Savings)	**$0.3**

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

6. Private Employer Impacts

We estimate that private employers in Vermont will spend about $696.3 million on health benefits in 2004 (***Figure 14***). This includes total benefits and insurer administrative costs less employee premium contributions. Private employer spending (i.e., $696.3) includes about $655.2 million in spending for workers and dependents and $41.8 million in retiree benefits.

We estimate that health spending among firms that currently provide coverage would decline by about $14.2 million under the program. This includes about $20.5 million in savings to VHAP eligible firms who move to the program. This would be partially offset by an increase in the cost-shift to firms that continue with private coverage of about $6.3 million.

Spending for Buy-in coverage in non-insuring firms that decide to participate in the Buy-in would be about $10.5 million. This results in a net decrease in private employer spending for health benefits of about $3.7 million (i.e., 10.5 million – $14.2 million).

Among firms that now offer coverage, the VHAP Buy-in would result in savings to small employers who are eligible for the program while increasing costs among larger firms due to increased cost-shifting. Savings for small employers would average about $421 per worker in firms with under 10 workers and $292 per worker in firms with 10 to 24 employees (***Figure 15***). Spending would increase for firms with over 25 workers by an average of roughly $35 per worker due to the increase in cost-shifting.

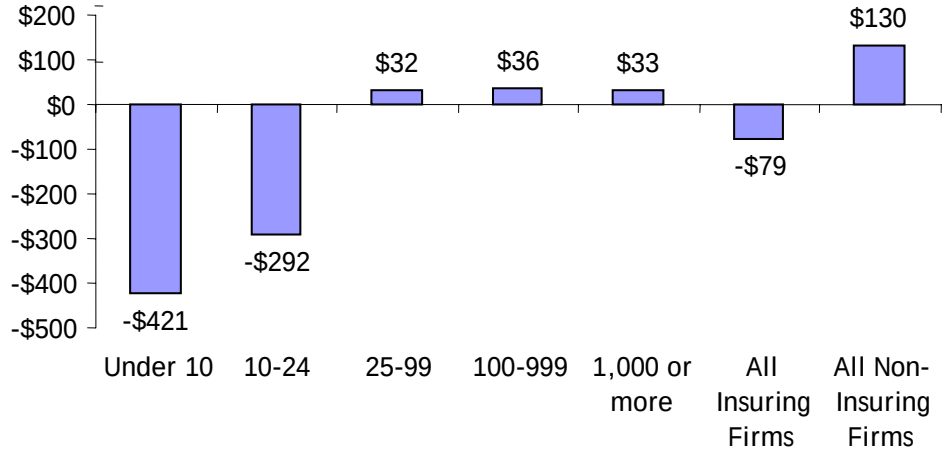
Figure 14
Changes in Private Employer Health Benefits Costs
Under the VHAP Buy-in 2004

(in billions)

	Insuring	Non-Insuring	Total
Private Employer Spending Under Current Policy			
Current			
Workers & Dependents	$655.2	--	$655.2
Retirees	$41.1	--	$41.1
Total	**$696.3**	**- -**	**$696.3**
Private Employer Spending Under the Policy			
Policy			
Workers & Dependents	$634.7	$10.5	$645.2
Retirees	$41.1	--	$41.1
Increased Cost-Shift	$6.3	--	$6.3
Total	**$682.1**	**$10.5**	**$692.6**
Net Change	**($14.2)**	**$10.5**	**($3.7)**

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 15
Change in Employer Health Benefits Costs Spending per Worker
Under the VHAP Buy-in in 2004



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

7. Impact on Household Health Spending

The VHAP Buy-in would result in an initial reduction in health spending for affected people of about $2.7 billion (***Figure 16***). Households who become enrolled in the Buy-in would save about $1.2 million due to reduced premium payments under the Buy-in. However, these savings would be more than offset by increased premiums due to the cost shift among people who continue with commercial insurance. However, family out-of-pocket costs for health services

would be reduced by about $0.6 million for newly insured people and those with improved coverage. This results in a net increase in health spending of about $3.3 million in 2004.

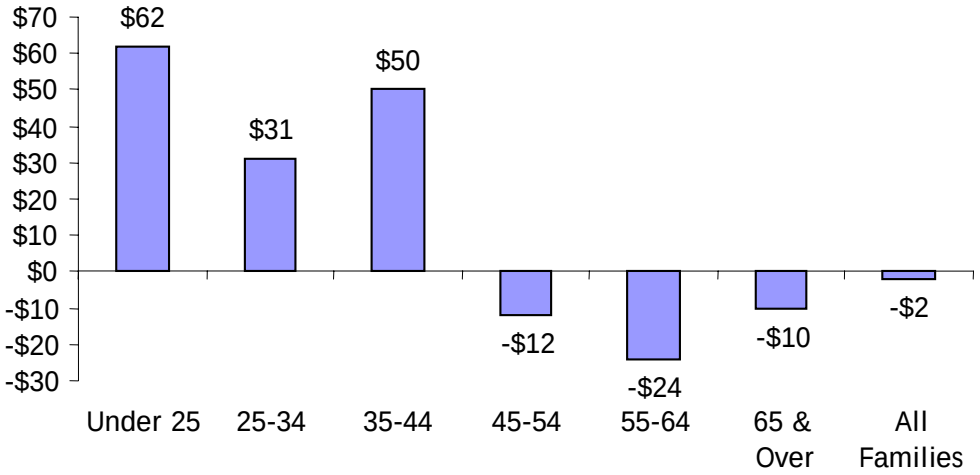
Figure 16
Impact of the VHAP Buy-in Proposal on Family Health Spending
(in millions)

	Without Wage Effects	With Wage Effects
Change in Family Premiums	$3.3	$3.3
Premiums Payments ($1.2)		
Increased Cost-Shift $4.5		
Change in Out-of-pocket	($0.6)	($0.6)
After-Tax Wage Effects [a/]	- -	($3.4)
Net Change	**$2.7**	**($0.7)**

a/ The decrease in after-tax wage income resulting from the program is counted here as an increase in family spending for health care.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

As discussed above, the changes in employer spending for health benefits are expected to be passed-on to workers in the changes in wages. In general, workers in non-insuring firms that decide to offer coverage would see wage reductions while workers in firms that see savings due to the Buy-in would see increases in wages. When all of these wage changes are included, we estimate that there would be a net increase in wages of about $3.4 million for workers. Thus, when the wage effects are included, health spending for households would be reduced by about $0.7 million. This is an average reduction in family health spending of about $2 per family (***Figure 17***).

Figure 17
Change in Average Family Health Spending under the Buy-in Proposal in 2004 by Age of Family Head [a/]

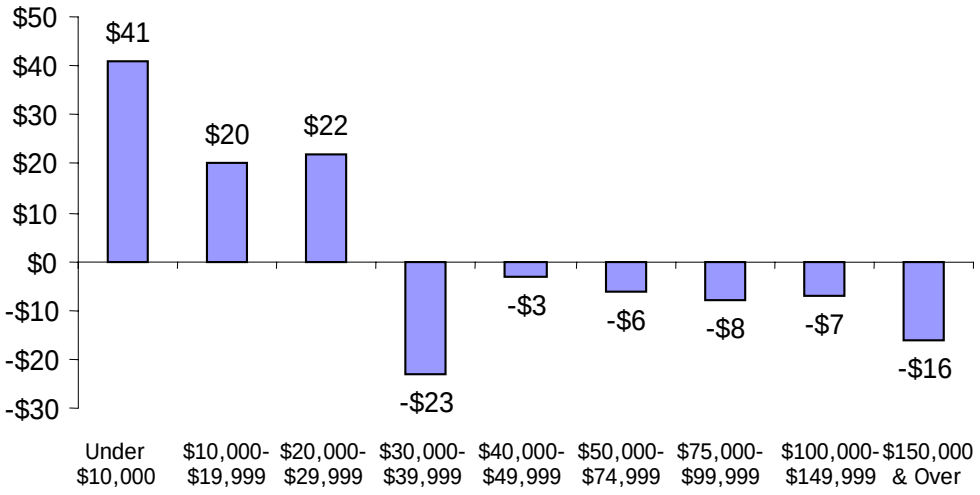


Source: Lewin Group estimates using the Health Benefits Simulation Model.

Families headed by people over the age of 44 would on average see savings while younger families would see increases in health spending. This reflects the fact that much of the increase in coverage would be among younger people, where coverage rates are lowest, resulting in increases payments for health insurance premiums for these people. Savings would tend to be higher among older age groups where many of the Vermonters who now purchase non-group coverage are concentrated.

The effects of the program on health spending vary across families by income level. Spending increases by about $41 per family with incomes under $10,000 and about $20 per family with incomes between $10,000 and $19,999 (***Figure 18***). This reflects the fact that many of the uninsured who would become covered under the program would be in lower-income groups and would now be paying a premium. Families with incomes in excess of $30,000 would on average see savings. This reflects the fact that workers in buy-in eligible firms who would benefit from the Buy-in are distributed across all income groups, despite the maximum average salary limit for employers of $31,000 (most insuring firms include a mix of workers at widely varying wage levels).

Figure 18
Change in Average Family Health Spending under the Buy-in Proposal: by Family Income



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

D. Reserve Requirements

As an insuring entity, the VHAP Buy-in program would need to establish reserves of funds to assure that the plan can meet its obligations. In this section, we provide a summary of the reserve requirements for health care benefit plans (i.e., health insurance plans). This summary is based on generally accepted actuarial principles. Specific statutory, regulatory, or accounting requirements may result in different reserves being established, or they may impact the way in which these reserves are calculated.

There are two main types of health insurance reserves: the Incurred But Not Reported (IBNR) reserve, and the claim fluctuation reserve.

1. IBNR Reserve

As the name suggests, an IBNR reserve is established in order to recognize a health plan's liability for claims that have been incurred but have not yet been reported to the plan. This recognizes that, in general, there is a time lag between (a) the date on which a claim for health care benefits is incurred, and (b) the date on which the health plan is formally notified of the existence and amount of the claim.

A claim is incurred as soon as a service that is covered under the plan's benefit provisions is rendered by a qualified health care provider to a member (i.e., enrolled individual) of the plan. The rendering of the service creates a liability for the plan, for eventually it will have to pay – either to the provider or to the member – the amount of the benefit that is associated with the covered service (as defined by the terms of the plan). Actual payment, however, must wait at least until the plan has been notified of this event, i.e., until a claim has been submitted (or "reported") to the plan.

The payment of a claim is further delayed by the amount of time that it takes for the plan to adjudicate the claim and to issue a payment. Finally, an additional delay will occur if the payment is in the form of a check which must be transmitted to the recipient, deposited or cashed, and then cleared by the financial institution that accepted the deposit. (This last delay is avoided if a wire transfer of funds is used.) Because of these additional delays, some health plans establish separate reserves for "claims in process" (i.e., in adjudication) and for "checks issued but not cleared." Other plans simply factor these delays into the calculation of the IBNR reserve (sometimes renamed the Incurred But Not Paid reserve), with the understanding that this reserve includes the liability for all claims that have been incurred but for which the final transfer of funds has not yet occurred.

The most accurate way to estimate the dollar amount required for the IBNR reserve is to use a "lag report." This report shows, for each month during some prior year, what portion of the claims that the plan *incurred* during that month were *paid* in that month and in each subsequent month. Based on this information, we can estimate what portion of the claims incurred in a *recent* month (or "incomplete" month, or "immature" month) remain to be paid as of a given date (***Figure 19***). A sample lag report is shown below. (Due to the layout of the numbers in the report, it is sometimes referred to as a "claims triangle.")

If a lag report isn't available for the plan, then the IBNR reserve can be set based on a rough estimate of the average amount of time it takes for a claim to be paid (i.e., the average lag between date incurred and the data of payment). For example, a quick examination of claims and payment data may show that, on average, claims are paid about 1½ to 2 months after they are incurred. In that case, the IBNR should be set equal to the amount of claims that the plan would expect to pay over a 1½-month or 2-month period.

Figure 19
Sample Lag Report for Incurred But Not Reported (IBNR) Illustration

	Paid In						
Incurred In	**Jan-00**	**Feb-00**	**Mar-00**	**Apr-00**	**May-00**	**Jun-00**	**Jul-00**
Jan-00	$ 253,483	$ 881,361	$ 536,855	$ 202,514	$ 69,616	$ 54,490	$ 24,891
Feb-00	-	223,550	995,862	405,488	168,498	104,359	35,744
Mar-00	-	-	321,571	1,030,317	292,017	190,111	102,781
Apr-00	-	-	-	322,949	1,023,567	368,429	192,112
May-00	-	-	-	-	317,930	1,063,327	345,990
Jun-00	-	-	-	-	-	430,558	985,912
Jul-00	-	-	-	-	-	-	378,230

Although the size of the plan (in terms of the number of participants or the dollar amount of monthly claims) generally is not *explicitly* recognized in the IBNR calculation, plan size is taken into account *implicitly* in deciding how conservative the reserve should be. For example, the IBNR reserve for a small plan might be set at a higher multiple of monthly claims than the IBNR reserve for a large plan, even if the two plans have the same average lag time between the date the service is incurred and the date of claims payment. This is because the claim level and payment lag are less predictable for the smaller plan than they are for the larger plan. That is, random fluctuations in claim levels and payment lags will be *relatively* greater for the smaller plan, and thus the smaller plan's IBNR reserve should be set at a more conservative level (i.e., at a higher multiple of monthly claims) than the corresponding reserve for the larger plan.

2. Claim Fluctuation Reserve

The claim fluctuation reserve is established to provide a financial cushion against unexpectedly large total claims. An unexpectedly large total dollar payout for a health plan can result from a greater-than-expected *number* of claims, or from a greater-than-expected *dollar amount* per claim (also known as the claim "severity"), or both. The end result can be a financial shortfall for the plan, in which premium income is insufficient to cover claims expenses.

Financial shortfalls of this kind may result from underestimating the *trend*, or annual increase in claims per member, when setting the premiums for the plan. Such underestimation cannot always be avoided: health care cost increases can be quite erratic, due to changes in consumer behavior or provider practices, or due to the introduction of new technologies (including new drugs), or due to purely economic factors. The inherent difficulty of predicting health care cost increases is one factor that may motivate a plan sponsor to set up a claim fluctuation reserve, so that the plan will have an "insurance policy" against higher-than-anticipated cost trends.

However, even if the trend used to set the premiums is *not* underestimated – that is, even if it predicts with perfect accuracy the per-member cost increase experienced by health plans *in general* – an individual health plan may still experience a financial shortfall simply due to the random fluctuations that inevitably will occur in the number and severity of claims *for that plan*. That is why the reserve is called a claim fluctuation reserve: its primary purpose is to protect the plan not against trend underestimation but against claim fluctuation.

The claim fluctuation reserve can be funded either (1) by building a margin into the premiums paid by (or on behalf of) plan members, or (2) by setting aside a portion of the plan's capital or surplus at the inception of the plan's operations. In deciding how large a claim fluctuation reserve to establish, in general one cannot simply say "more is better." The need to keep premiums at a competitive and affordable level limits the amount of margin that can be built into the premiums in order to fund a reserve. Likewise, the limitations of a plan's capital resources, or restrictions on the use of that capital, may constrain the amount that can be set aside to establish an initial claim fluctuation reserve.

The general principle used in setting the dollar amount for a claim fluctuation reserve is that the reserve should be just large enough so that it is highly unlikely that the total claims (plus administrative expenses) of the plan will exceed the sum of the premiums and the claim fluctuation reserve. It is up to the plan sponsor (or, in some cases, regulatory agencies) to decide how to define "highly unlikely," but one possible standard is a probability of 5 percent or less that a shortfall will occur. Alternatively, one could use a shortfall probability of 1 percent or even 0.1 percent.

In contrast to the IBNR reserve, the claim fluctuation reserve explicitly takes into account the number of members covered by the plan. For example, suppose a plan has 10,000 covered members, and the premiums are set so that the total premium income equals the *expected* total claims plus expenses. If the plan sets aside a portion of its capital equal to 5 percent of anticipated premium income in order to establish a claim fluctuation reserve, then the probability that the *actual* total claims plus expenses will exceed the total premiums plus reserve is about 2.1 percent. If the claim fluctuation reserve is increased to 10 percent of the total premium, then the shortfall probability drops to less than 0.1 percent.[19]

However, if a plan covers only 1,000 members, and it establishes a 5 percent-of-premium claim fluctuation reserve, then it faces a shortfall probability of 23.6 percent. Even with a reserve equal to 10 percent of the total premium, the shortfall probability is still 8.6 percent. For a group of this size, it would take a 15 percent claim fluctuation reserve to reduce the shortfall probability to about 2.4 percent, and a 25 percent-of-premium reserve to reduce the shortfall probability to under 0.1 percent.[20]

It should be noted that all of these probabilities are based on the assumption that the health care cost trend used to calculate the premiums (and hence the claim fluctuation reserve) is completely accurate. If the trend is underestimated, then the likelihood of experiencing a shortfall with a given claim fluctuation reserve is higher – or, to look at it another way, it would take a larger claim fluctuation reserve to keep the shortfall probabilities down to the levels cited above.

[19] Olsho, David and Mark McAllister: "Medical Aggregate Stop Loss Claim Frequencies," *Society of Actuaries Health Section News*, August 2000, p. 8.

[20] *Ibid*.

E. Selection Effects

Adverse selection is a phenomenon where by a give insurance pool acquires a disproportionate share of people with high health care costs. For example, in the absence of the community rating requirements in Vermont, insurers would be permitted to vary premiums by age, industry, health status and other group characteristics. In such a model, firms with older and sicker workers would find that the Buy-in premium is less than what they must pay in the commercial market for comparable coverage and would therefore tend to enroll in the Buy-in. Less costly groups would tend to obtain coverage in the commercial market because the rating rules permit the insurer to charge a premium that reflects their lower expected costs. This would result in the accumulation of higher cost individuals in VHAP, requiring an increase in the premium.

In our simulations of the Buy-in discussed above, our model does not predict a significant amount of adverse selection into the VHAP Buy-in program. The reason for this is that under the existing community rating laws in the state, the premium charged by an insurer for a given insurance product is the same for all applicants regardless of age and health status. Therefore, for a given benefits package, there is no particular advantage for high cost groups to join VHAP. Also, there are few insurance carriers in the state suggesting only limited premium variation across carriers, which would also limit the degree of selection across carriers.

Moreover, most of the small group and individual market is expected to enroll in the program. As shown in ***Figure 20.*** We estimate that there are about 91,076 people in small employer groups and the individual insurance market who are eligible for the program. Of these, we estimate that about 47,129 people would enroll (about 52 percent). Consequently, we expect there to be only very limited selection effects because most of the eligible population would be in the pool.

Figure 20
VHAP Buy-in Program with Current Community Rating Requirements [a/]

	Buy-in With Current Community Rating Law
Eligible	91,076
Enrollment	47,129
Reduction in Uninsured	7,158
Program Cost (millions)	$118.8
Program Revenue (millions)	$118.8
Net Cost to State (millions)	--

a/ Assumes the Buy-in program described above where eligibility is limited to individuals living below 300 percent of the FPL, and small employers (25 or fewer workers) with average salaries of less than $31,000 per worker.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

However, there are some ways in which selection could occur that our model is not sensitive enough to quantify. For example, insurers could target their marketing efforts on industries and groups known to have favorable risk profiles, thus leaving the more costly groups to move into

VHAP resulting in significant risk selection. Also, many employers have the option of taking coverage under association health plans that often offer coverage to member firms at a lower-cost, which can leave higher-cost groups to select between VHAP Buy-in and the commercial market.

Figure 21 presents estimates of the number of people enrolling in the buy-in with the current community rating laws for the individual market and small employer groups by age and income.

Figure 21
Change in Private Coverage Under the Buy-in Proposal by Age and Income: Current Community Rating Law [a/]

	Reductions in Private Coverage		Reduction in Uninsured	Total Buy-in Enrollment
	Small Employers	Individual		
Age				
Under 19	5,505	1,816	862	8,183
19-24	2,461	2,122	1,333	5,916
25-34	3,495	1,092	1,028	5,615
35-44	4,023	1,792	1,616	7,431
45-54	6,879	1,879	1,446	10,204
55-64	7,202	1,756	873	9,829
Family Income				
Less than $10,000	769	1,164	981	2,914
$10,000-$14,999	850	952	1,367	3,169
$15,000-$19,999	1,102	2,020	1,000	4,122
$20,000-$29,999	4,041	3,365	2,108	9,514
$30,000-$39,999	5,419	1,397	502	7,318
$40,000-$49,999	3,104	511	402	4,017
$50,000 & Over	14,140	1,047	798	15,985
Total	**29,515**	**10,456**	**7,158**	**47,129**

a/ Assumes Buy-in discussed above where eligibility is limited to individuals living below 300 percent of the FPL, and small employers (25 or fewer workers) with average salaries of less than $31,000 per worker.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

F. Alternative Buy-in Eligibility Criteria

In the analyses presented above, we assume that the Buy-in is available to: individuals without access to employer coverage with incomes below 300 percent of the FPL; and small employers (25 or fewer workers) with an average payroll of less than $31,000 per worker. Eligible individuals and employers are permitted to enroll in VHAP even if they are currently covered under commercial insurance.

In this section we present estimates of the cost and coverage impacts of the Buy-in under alternative eligibility criteria. We also summarize the impact of the Buy-in on uncompensated care and the cost-shift under these alternatives.

1. Alternative Eligibility Criteria

Under the scenario analyzed above, which we call scenario # 1, we estimate that there are about 91,076 people who are eligible of whom about 47,129 would enroll. Of those who enroll, about 7,158 would be uninsured people who either decide to purchase coverage as individuals or are employed in a firm that decides to take coverage (***Figure 22***). The remaining 39,971 people are currently insured people who shift from commercial coverage to the Buy-in.

To avoid the shift of currently insured people to the Buy-in, eligibility could be limited to only those low-income people who are currently uninsured by requiring a waiting period before enrollment. For example, in Scenario #2, we assume that to be eligible, people enrolling as individuals are required to be uninsured for 12 months prior to enrolling in the program, and small employers must not have offered insurance to their workers for at least 12 months to be eligible. Under this scenario, enrollment is reduced from 47,129 people under the first scenario without a waiting period to about 10,764 people with a waiting period requirement (***Figure 22***).

The Buy-in could be extended to people at higher income levels as well. For example, the income limits under scenario #1 are set at 300 percent of the FPL for individuals and an average salary of $31,000 for small employers. Eliminating these income eligibility limits would result in enrollment of about 92,923 people without a waiting period requirement (scenario #3) and about 13,481 people with a 12 month waiting period requirement (scenario #4). In fact, most individuals and small employers would find the VHAP Buy-in premium to be less than what they are now paying for commercial coverage due to the lower provider payment levels under the Buy-in.

Another approach would be to increase the firm size eligibility level from 25 or fewer workers to 50 or fewer workers. In this example, we have assumed that eligibility would be limited to individuals with incomes below 300 percent of the FPL and/or employers with an average payroll of less than $31,000 per year. Under this scenario, i.e., scenario # 5, buy-in enrollment grows to about 65,240 people, of whom about 8,741 would be currently uninsured people who would take coverage due to the Buy-in. Total program expenses would be about $165.6 million.

2. Impact on Insurance Markets

The VHAP Buy-in could have a significant impact on the Vermont health care system. For example, the program would dramatically reduce the number of people purchasing coverage in three important insurance markets in the state, which together cover about 133,200 Vermonters (***Figure 23***). These include the non-group market (17,718 people), association health plans (82,443 people), and the small group market (33,048 people). Under our first scenario, (i.e., with income limits; no waiting period, and firms with 25 or fewer workers), we estimate that about 30 percent of those currently enrolled in these markets (39,971 people) would shift to the VHAP Buy-in to take advantage of the lower premium.

The Buy-in could be structured in ways that would attract an even greater share of the commercially insured population. For example, the reduction in enrollment in these markets would be about 42.4 percent (56,499 people) if the firm size eligibility level is increased from 25 or fewer workers as under scenario #1, to 50 or fewer workers as in Scenario # 5. Alternatively,

Figure 22
Buy-in Enrollment Under Alternative Eligibility Criteria

	Scenario # 1: With Income Limits; No Waiting Period; 25 or Fewer Workers	Scenario # 2: With Income Limits; With Waiting Period; 25 or Fewer Workers	Scenario # 3: Without Income Limits; No Waiting Period; 25 or Fewer Workers	Scenario # 4: Without Income Limits; With Waiting Period; 25 or Fewer Workers	Scenario # 5: With Income Limits; No Waiting Period; 50 or Fewer Workers
Eligibility for Individuals	• Incomes Below 300% of FPL • Without access to employer coverage • No waiting period since last covered	• Incomes below 300% of FPL • Without access to employer coverage • Uninsured 12 months unless job change or involuntary loss of coverage	• No income limit • Without access to employer coverage • No waiting period since last covered	• No income limit • Without access to employer coverage • Uninsured 12 months unless job change or involuntary loss of coverage	• Incomes Below 300% of FPL • Without access to employer coverage • No Waiting Period since last covered
Employer Eligibility	• 25 or fewer workers • Average salary below $31,000 • No waiting period • Employer pays half of premium • 75% of workers enroll	• 25 or fewer workers • Average salary below $31,000 • Have not insured in 12 months • Employer pays half of premium • 75% of workers enroll	• 25 or fewer workers • No average salary limit • No waiting period limit • Employer pays half of premium • 75% of workers enroll	• 25 or fewer workers • No average salary limit • Have not insured in 12 months • Employer pays Half of Premium • 75% of workers enroll	• 50 or fewer workers • Average salary below $31,000 • No waiting period • Employer pays half of premium • 75% of workers enroll
Program Enrollment and Costs [a/]					
Eligible People	91,076	52,298	154,214	65,506	108,076
Enrollment	47,129	10,764	92,923	13,481	65,240
Shift from Commercial	39,971	3,606	83,311	3,869	56,499
Newly Insured	7,158	7,158	9,612	9,612	8,741
Premiums (in millions)	$118.8	$26.8	$235.7	$33.3	$165.6

a/ Each scenario is simulated based upon the benefits package described above in ***Figure 3***. We estimate a premium for adults of $235 for small employer groups and $207 in the individual market. Assumes full phase in of enrollment in 2004
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 23
Summary of the Impacts of the Buy-in Under Five Variations in Eligibility in 2004 [a/]

	Scenario # 1: With Income Limits; No Waiting Period; 25 or Fewer Workers	Scenario # 2: With Income Limits; With Waiting Period; 25 or Fewer Workers	Scenario # 3: Without Income Limits; No Waiting Period; 25 or Fewer Workers	Scenario # 4: Without Income Limits; With Waiting Period	Scenario # 5: With Income Limits; No Waiting Period; 50 or Fewer workers
Currently Insured in Affected Markets [b/]	133,209	133,209	133,209	133,209	133,209
Private Insured Shifting to Buy-in [c/]	39,971	3,606	83,311	3,869	56,499
Percent of Market	30.0%	2.7%	62.5%	2.9%	42.4%
Reduction in Uninsured [d/]	7,158	7,158	9,612	9,612	8,741
Total Buy-in Enrollment	47,129	10,704	92,923	13,481	65,240
Total Program Costs (millions)	$118.8	$26.8	$235.7	$33.3	$164.4
Benefits (millions)	$98.0	$22.1	$194.4	$27.5	$135.6
Administration (millions)	$20.8	$4.7	$41.3	$5.8	$28.8
Reductions in Provider Payments [e/]	$27.9	$2.5	$58.1	$2.7	$39.4
Reductions in Uncompensated Care	$5.3	$5.3	$7.1	$7.1	$6.5
Change in Cost-Shift [f/]	$15.2	($2.8)	$34.4	($3.0)	$22.2
Savings Per Participant	$698	$694	$697	$710	$697
Increased Cost for Remaining Commercially Insured (per person)	$47	($8)	$124.0	($9.0)	$72

a/ The scenarios with income limits (scenarios # 1, 2 and 5) assume that eligibility is limited to individuals with incomes below 300 percent of the FPL and/or workers and dependents in firms with an average salary of less than $31,000 per worker.
b/ Includes people insured in: the non-group market (17,718 people); the small group market, which includes firms with 50 or fewer workers (33,048 people); and association health plans (82,443 people).
c/ Eligible individuals and groups are assumed to shift to the buy-in if the buy-in premium is less than what they currently pay for coverage.
d/ The uninsured are assumed to enroll based upon studies of the impact that reductions in premiums have on the likelihood that employers and individuals will take coverage.
e/ Reductions in provider payments for services provided to people who shift from commercial insurance to the buy-in.
f/ About 75 percent of the net changes in provider reimbursement and uncompensated care is assumed to be passed-on to people who continue to have commercial insurance in the form of higher charges, which is known as the cost-shift..
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

the loss of enrollment in these markets would be even greater if we were to eliminate the income eligibility limits for workers and employers as under scenario # 3. This would result in a loss of about 62.5 percent of the people enrolled in these insurance markets (83,311 people).

It is unclear whether the affected insurance markets would be viable with the loss of such a large portion of the enrollment. An enrollment loss of this magnitude could eliminate any economies of scale that exist in administering these insurance pools and greatly destabilize premiums by reducing the predictability of losses for such groups. This together with the increase in the cost-shift would increase premiums in these markets resulting in a loss of coverage among those who remain in the commercial markets.

Loss of such a large portion of the market to the Buy-in could result in the withdrawal of the few insurers that remain in the individual and small group markets. For example, BISCHA data indicate that about 93.5 percent of people who are fully-insured (i.e., excluding people in self-funded plans) was concentrated among the four largest carriers in the state.[21] Some of these insurers may no longer be able to justify the expense of operating plans in Vermont for such a small number of people. Moreover, the prospect of competing for enrollment with a state plan that is able to undercut provider payments in this way could discourage insurers from participating in the Vermont insurance markets.

One way of reducing this effect would be to use a waiting period. For example, we could add a waiting period requirement to scenario # 1 that limits eligibility to only individuals who have been uninsured for at least 12 months and employers who have not offered insurance in the past year, as under scenario # 2. Participation in the program would be limited to three years so that these individuals do not permanently escape the private markets and to further minimize the loss of market share.

VHAP Buy-in enrollment under this scenario would drop to about 10,704 people, of which about 7,158 people would be newly insured. There still would be some displacement of existing coverage because some of those who would become covered by their employer under the program already purchase non-group coverage (3,606 people). However, this represents only about 2.7 percent of enrollment in the affected markets.

It is important to note that some employers may be prepared to discontinue coverage for their workers for a one-year period so that they will qualify for enrollment in the following year. The extent to which this would occur is unclear. Most employers who provide coverage do so because it is necessary to attract and retain workers. Thus, it would be difficult for employers to eliminate coverage, even for one year. The employers that do so are likely to be ones that would have discontinued coverage anyway due to rising costs.

Similar provisions are included in the Healthy New York program in New York state. This program that provides subsidized coverage to low-wage small firms and low-income individuals that have not had/offered coverage in 12 months for a maximum enrollment period

[21] Includes BCBS of Vermont, MVP health plan, TVHP health plan, and Cigna. See: "Health Insurance Coverage Estimates for Vermont Residents, 1999-2002," BISHCA, July 10, 2003.

of three years. However, the program is relatively new, so we do not have enough experience with it to estimate its long-term impact on affected insurance markets.

3. Cost Shifting

The primary attraction of the Buy-in to consumers is that the premium would be substantially lower than what they would pay in the commercial market for comparable coverage. This is attributed almost entirely to the fact that the Buy-in would pay providers 110 percent of Medicare payment levels, which are between 20 percent and 30 percent lower than what private insurers are now paying for the same services. The lower premiums in the Buy-in are designed to encourage some uninsured individuals and non-insuring employers to take coverage. However, the primary effect of the program would be to cause many individuals and employers who already have insurance to discontinue their commercial coverage and enroll in the Buy-in.

One of the greatest concerns with this effect is that it would increase cost-shifting. Cost-shifting is the process whereby health care providers recover shortfalls in payments under public programs and uncompensated care costs by increasing charges for services provided to commercially insured patients. The available evidence indicates that up to 80 percent of payment shortfalls under public programs are passed-on to commercial payers in the form of higher charges. Thus, we can expect that most of the reduction in provider income resulting from people shifting from commercial coverage to the Buy-in would be passed-on to those who remain with commercial insurance in the form of higher charges.

For example, in scenario # 1 (i.e., with income limits; no waiting period; and firm size limit of 25), about 85 percent of those who enroll in the VHAP Buy-in would be people who shift from commercial coverage to the program (39,971 people). The reduction in provider payments for those who shift to the Buy-in would be about $27.9 million. This would be partially offset by a reduction in uncompensated care costs of $5.3 million for providers due to the reduction in the number of uninsured people under this scenario (i.e., 7,158 people). We estimate that roughly three-quarters of the net reduction in provider revenues, i.e., about $15.2 million, would be passed-on to commercially insured people through the cost shift.

Under scenario # 1, we estimate that the cost of coverage for those who shift from commercial insurance to the Buy-in would be reduced by about $700 per person for the year. However, costs for those who continue with commercial coverage would increase by about $47 per person. This includes all commercially insured people including those in the non-group market, the small group market, association health plans, the large group market, and self-funded plans (currently 361,000 people). Thus, when the cost-shift is included, the Buy-in effectively reduces costs for a select group of privately insured people at the expense of others who remain with commercial insurance.

Not all of the variants of the Buy-in proposal would increase the cost-shift. For example, if we were to add a 12-month waiting period requirement, as under scenario # 2, the cost-shift is actually reversed. The reason for this is that the reduction in the uninsured population under this scenario (i.e., 7,158 people) would reduce uncompensated care costs, while eliminating nearly all of the reduction in provider income that comes from allowing currently insured

people to shift to the Buy-in. In fact, the cost-shift is actually reduced by a modest amount (i.e., $2.8 million) under this scenario.

G. Conclusions

The VHAP Buy-in model could reduce the number of Vermonters without insurance by up to about 9,600 people, depending upon eligibility provisions. However, this is only about 15 percent of the 61,700 people in the state who are now without coverage. This is because even with the 25 percent reduction in provider payment rates, the premiums would continue to be unaffordable to many of the uninsured.

The program could result in a loss of insurers from the already ailing non-group and small group markets of Vermont, resulting in reduced access to coverage for those who are not eligible for the Buy-in. Premiums are also likely to increase in these insurance markets due to a loss of economies of scale in administration, an increase in cost-shifting and increased uncertainty in predicting benefits costs. Concerns over potential adverse selection in the commercial plans that remain could also discourage insurers from participating in the Vermont Insurance markets.

The migration of currently insured people to the Buy-in could be nearly eliminated by imposing a 12 month waiting period requirement on individuals and employers. This approach would avert a large scale shift of insured people to the Buy-in while actually reducing cost-shifting from uncompensated care for the uninsured who become covered. Participation could be limited to a maximum of three years so that these employers and individuals do not permanently escape the existing insurance markets. However, the fairness of this approach is unclear given that those who are already providing coverage would be bared from obtaining the same low-cost coverage available to otherwise identical employers.

United States
Department of Health and Human Services
Health Resources and Services Administration

State of Vermont

Agency of Human Services
Office of Vermont Health Access

State Planning Grant

Addendum

September 30, 2004

EXECUTIVE SUMMARY

In 1992, the Vermont's Governor appointed the Blue Ribbon Commission on Health to explore options for ensuring access to health care for all Vermonters. The Commission's recommendations were subsequently incorporated into Act 160.

Since 1992, Vermont has devoted significant resources to planning and implementing creative strategies for making coverage available to uninsured Vermonters, as evidenced by three major health coverage initiatives:

- The Dr. Dynasaur program was created as a state-funded comprehensive health assistance program, serving children through age six and uninsured pregnant women not eligible for Medicaid. In 1992, the program was integrated into Medicaid; in 1995 the program became part of the VHAP waiver; and in 1998, it was further expanded with the SCHIP program. Enrollment has risen steadily since 1989 and currently Dr. Dynasaur insures approximately one of every three Vermont children.

- The Vermont Health Access Plan (VHAP) is Vermont's most significant coverage expansion initiative. VHAP operates under a Section 1115a Medicaid research and demonstration waiver. Currently, the VHAP covers over 18,000 previously uninsured adults, directly contributing to the reduction in uninsured Vermonters below 150% of FPL from 30,000 in 1993 to 9,000 in 1997.

- VScript, a state-funded program for those with income above the Medicaid limits, addresses the issue of affordable prescription coverage for the low-income Medicare population. Since 1989, VScript has transformed into VHAP-Pharmacy as part of the implementation of the 1115a Medicaid waiver. Currently, VScript insures approximately 12,000 individuals.

For over a decade, Vermont's commitment to increasing access to health coverage has enabled Vermont to maintain a relatively low uninsurance rate – from 17 percent of the population in 1992 to approximately 10 percent in 2002. However, Vermont continues to seek options to maintain and improve the uninsurance rate. While the percentage of uninsured Vermonters remains low, the number of uninsured Vermonters has increased in recent years.

Under the initial Health Resources and Services Administration (HRSA) State Planning Grant (SPG), Vermont fielded the 2000 Vermont Family Health Insurance Survey, conducted focus groups (i.e., uninsured, employers, insurers, providers) and developed policy options. Under the Supplemental SPG, Vermont selected three policy options (i.e., VHAP Buy-In, Premium Assistance and Medical Savings Accounts) for further study. The VHAP Buy-In study has been completed and is included with this report. The Premium Assistance and Medical Savings Account studies will be completed by August 2005.

SECTION 1. UNINSURED INDIVIDUALS AND FAMILIES

In 2002, approximately 62,000 (10 percent of Vermonters) were without health insurance (Table 1). According to the United States (U.S.) Census Bureau, the national uninsured rate was 15 percent in 2002.[1] Compared to other states Vermont has lower income eligibility thresholds for the state Medicaid program. This may account for some of the difference in the uninsured rates between the U.S. and Vermont. For example, children in Vermont households earning up to 300 percent of the federal poverty level ($45,200 for a family of three in 2002) were eligible for the Vermont Medicaid program in 2002.[2] Table 1 illustrates the number of insured and uninsured Vermonters for the period 1997 through 2002.

Table 1 – Vermont Health Insurance Coverage, 1997-2002

	1997	1998	1999	2000	2001	2002	1997-2002 Change
Private Market Total (Insured + Self-Insured)	384,636	382,236	376,462	371,774	362,163	359,794	-24,842
Medicare	85,562	86,588	87,644	87,937	90,214	91,170	5,608
Medicaid	86,803	87,598	91,173	97,664	103,696	102,736	15,933
Uninsured Total	40,640	43,847	48,942	51,453	57,017	62,892	22,252
Vermont Population Total	597,641	600,269	604,221	608,828	613,090	616,592	18,951
Uninsured Percent of Population	6.8%	7.3%	8.1%	8.5%	9.3%	10.2%	

Quantitative and qualitative research was conducted to develop an in-depth understanding of the characteristics of the uninsured and their susceptibility to potential coverage strategies. The research process was iterative in that the findings from each activity informed the next (e.g., an early research finding was that no single option or program could expand coverage to include all groups of the uninsured, but rather that multiple options needed exploration).

Quantitative Research: The 2000 Family Health Insurance Survey data indicated that in 2000, there were 51,453 persons without health insurance in Vermont. This was equal to 8.5 percent of Vermont's population. About 69 percent of the uninsured indicated that they had been uninsured for over a year.

The data also showed that young adults have the highest concentration of uninsured persons. About 20 percent of persons age 18 to 29 were uninsured and accounted for 35 percent of the uninsured in the state. The percentage of persons without coverage for those age 30 to 44 and age 45 to 64 was 10 percent and 7 percent respectively. About 12 percent of the uninsured were children under the age of 18.

The uninsured were found at all income levels. Approximately 51 percent of the uninsured were living below 200 percent of the Federal Poverty Level (FPL). Another 22 percent had incomes between 200 percent and 299 percent of the FPL while 26 percent had incomes in excess of 300 percent of the FPL. Based on these data, it is estimated that 39 percent of Vermont's uninsured (about 20,000 people) are actually eligible for Medicaid, VHAP, or Dr. Dynasaur but are not enrolled.

Qualitative Research: Focus groups were conducted with uninsured Vermonters to understand the factors that led to their being uninsured and to determine their willingness to pay for different health insurance benefit plans. All participants agreed that having health insurance is very important for themselves and for their families. Most had health insurance at one point in their lives but had lost it when they changed employers. Many reported they would enroll in a plan if they received a significant raise or went to work for an employer who offered health insurance. Many acknowledged that they are "gambling with their health" and reported being uneasy about being uninsured.

Reasons for not having health insurance varied. The majority of participants lost their health insurance coverage because either they or a spouse changed jobs and were no longer offered health insurance as a benefit through an employer. Some participants were working at part-time or seasonal jobs, which do not offer health insurance. Several participants chose to leave their jobs to take care of family members at home; others were self-employed. The groups agreed that the main barrier to coverage the uninsured face is the cost of health insurance plans.

SECTION 2. EMPLOYER-BASED COVERAGE

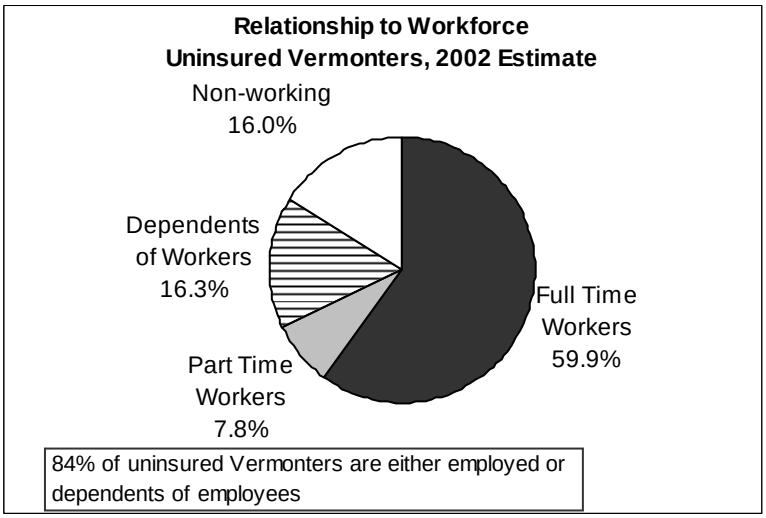
Employer focus groups and structured interviews were conducted to gain their perspectives of the uninsured; employers who offer insurance reported being very happy to be able to do so, while most of those not offering it reported they would like to be able to do so. Employers who do not offer health insurance identified cost as the primary barrier to offering coverage, including: premium levels, the unpredictability of costs in the future; and the resources required to research and administer plans. (Information was also collected from employers to determine the criteria they use to select insurance for their employees and determine their likely participation in coverage expansions.)

In 2001, comparable to the national average of 78 percent, about 77 percent of Vermont's private-sector employees were eligible for health insurance benefits where employers offered health insurance.[3] In 2002, 63 percent of all Vermonters, including workers and their dependents, were covered by employer-sponsored health coverage compared to a national average of 61 percent.[4] According to the 2000 Vermont Family Health Insurance Survey, 94 percent of the 365,000 Vermonters with private health insurance obtained coverage through employment-related arrangements such as current employment, COBRA or retirement plans and only 5 percent of the privately insured purchased insurance on their own in the non-group market.

On average, Vermont employers that offer health insurance contribute a major portion of the total insurance premium. In 2001, employers at private-sector establishments in Vermont that offered health insurance contributed 81 percent of the total premium for single coverage and 76 percent for family coverage; compared to a national average of 83 percent for single coverage and 77 percent for family coverage. Both nationally and in Vermont, consumers are assuming more of the cost of covered health services through deductibles, co-payments and coinsurance rates.

Vermont established high income thresholds for Medicaid to make the program available to the working uninsured and their families. Despite efforts to-date, Vermont's uninsured population continues to be comprised largely of working adults and their dependents. As Table 2 illustrates, in 2002, 84 percent of Vermont's uninsured lived in households with full- or part-time workers.

Table 2 - Employment Status of Uninsured Vermonters, 2002



Source: Estimate based on 2000 Vermont Family Health Insurance Survey and U.S. Census Breau 2002 Current Population Survey

SECTION 3. HEALTH CARE MARKETPLACE

Vermonters, like other Americans, obtain their health coverage from a variety of sources, including government programs (Medicare and Medicaid) and commercial health insurers. For the purposes of this section, "health coverage" and "health insurance" refer only to comprehensive major medical insurance and not other kinds of health insurance. The Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) is responsible for monitoring and regulating the commercial health insurance market in Vermont.

To understand how health insurance markets work, it is necessary to understand the different types of health coverage and the various parts of the health insurance market.

Private Coverage

Private Coverage (Self-funded and Insured) - Many employers make health coverage available to their employees and their dependents. The cost may be paid by employers, employees or some combination of both. There are two major categories of employer-sponsored health coverage: self-funded employer plans and insured plans.

> **Self-funded Employer Plans -** Under self-funded or self-insured plans, the employer is ultimately liable for paying health care claims. Self-funded employer plans that are subject to a federal law known as "ERISA" are not regulated by BISHCA and are not subject to state law.[6]
>
> **Insured Group Plans -** Under insured group plans, a health insurance company is ultimately liable for paying health care claims because the employer has purchased a contract of group health insurance (insured group plans). Insured group plans are subject to both federal and state regulation. These can be "large group" (more than 50 employees) or "small group" (50 or fewer employees and self-employed individuals). "Association" plans fall under the "small group" category in Vermont (associations are primarily composed of groups of businesses clustered by specific industries or types of businesses such as automobile dealers, chambers of commerce, agriculture, etc).

Individual Health Insurance - Individual or non-group health insurance is purchased from an insurance company (or its agent or broker) by persons who are not able to obtain health coverage from an employer. Individual health insurance is also a type of private insurance coverage.

In 2002, out of a total of 617,000 Vermonter, approximately 58 percent (360,000) obtained health coverage through the private market, including self–funded employer plans (150,000), insured group plans (192,000) and non-group plans (18,000).

Government Coverage

Health coverage obtained through government programs includes Medicare, Medicaid, coverage through the military service and similar programs.

In 2002, approximately 194,000 Vermonter received comprehensive major medical coverage through government programs. Specifically, 17 percent of the state's population was enrolled in Vermont's Medicaid program and 15 percent were enrolled in the federal Medicare program. (The count for Medicaid did not include Vermonters only receiving a pharmacy benefit or Vermonters dually eligible for Medicaid and Medicare. About 15,000 dually eligible Vermonters were counted under Medicare.) Less than one percent of Vermonters received their health coverage exclusively through the military.[7]

Insurance Market

As the Table 1 illustrates, the number of Vermonters with private (commercial) heath coverage actually fell by nearly 25,000 (6.5 percent) from 1997 to 2002, even as Vermont's total population rose by almost 19,000.

Some of the decline in private health coverage from 1997 – 2002 was offset by a growth in Medicaid enrollment, which increased by approximately 16,000 during the same period. However, the fastest growing segment from 1997 - 2002, in percentage terms, was the uninsured which rose at an average annual rate of 9.1 percent (54.8 percent overall).

In 2002, the largest segment of Vermont's insured market was association/trust (part of the small group market), accounting for 23 percent (82,000) of privately insured Vermonters. The second largest segment was the large group market, accounting for 21 percent (76,000). For the most part, these segments are experience rated. "Experience rated," also called "merit rated," means that rates are based on the claims experience of the particular insured. In Vermont, all large employer groups are experience rated — each large employer group has distinct rates determined on the basis of that employer group's claims experience.

The non-association segment of the small group market accounted for 9 percent (33,000) of Vermonters with private health insurance. The smallest insured market segment was the non-group or individual market, accounting for 5 percent (18,000) of Vermonters with private health insurance coverage. These two markets are community rated. "Community rated" means that the risks of all insureds in a defined "community" are blended together to develop the premiums for health insurance. A "community" is made up of all individuals having a particular insurance plan. Community rating spreads the cost of insurance evenly among all the individuals in a community with that plan, instead of charging significantly higher or lower costs for a person or group based on risk or claims experience. Vermont statutes require that each insurer set community rates in the small group and individual markets. In 2002, approximately 14 percent (51,000) of Vermonters in the privately insured market had community rated premiums.

There are differences between Vermont's community rating laws for the small group and individual markets. Vermont regulations require insurance companies selling health insurance in the small group market to charge the same premium to all their small group customers for the same type and amounts of coverage. They cannot charge small group members more or less than the community rate, regardless of the group's risk or claims experience, unless the group is exempt. In 2002, approximately 29 percent of Vermonters in the small group market were community rated; the remaining 71 percent were enrolled in the exempt association segment and were experience rated.

Vermonters receiving insurance through the individual market are subject to one of two types of community rating. By law, all insurers must calculate a person's premium by starting with the same rate for the same type and amount of coverage. Some insurers can then alter this pure community rate by adding or subtracting 20 percent, based on actuarial assumptions of how the person's age or gender influences their risk for making claims. Other insurers, nonprofit hospital

service corporations, like Blue Cross Blue Shield of Vermont, and nonprofit health maintenance organizations, like MVP, are prohibited by statute from using age or gender variations when setting non-group rates and thus use pure community rating.

In addition, under Vermont law, small employers can join an association that can ask for an exemption from the community rating law, thereby becoming experience rated. Rates for each "exempt" association are based on the claims experience of all members of the particular association and their dependents, rather than on the claims experience of all small employers throughout the state. Health insurance rates available to small employers through an exempt association tend to be lower than statewide small group rates when members' claims experience is lower. However, those rates may also be higher when members have higher-than-average claims experience. Approximately 71 percent of Vermonters in the small group market had health insurance through an exempt association in 2002.

In 2002, using earned premium as a measure for market share in comprehensive major medical insurance, the top carriers in Vermont were Blue Cross Blue Shield of Vermont (56 percent), MVP (19 percent); and The Vermont Health Plan (15 percent); accounting for over 90 percent of this Vermont market.

According to a national study, premiums increased an average of 12.7 percent for employer-sponsored health insurance in 2002 for the second consecutive year of double-digit increases.[8] In 2002 in Vermont; the average rate increase approved by BISHCA was 15.8 percent in the non-group market and 15.8 percent in the small group market (excluding associations). Premium rate changes can vary widely between groups in the experience rated large group and exempt association markets; rate increases in those markets are not regulated by BISHCA and data is currently not available on the average rate increase experienced by those markets.

In addition to comprehensive major medical insurance, there are other types of insurance with some coverage of health or health care related services or costs including non-comprehensive coverage (hospital only), Medicare supplement or Medigap, specified disease, long term care, accident, dental and disability. In 2002, of the total earned premium reported by accident and health insurers in Vermont ($710 million), comprehensive major medical insurance accounted for 74 percent ($524 million) of the total, followed by Medicare supplement accounting for 6 percent ($46 million) and disability insurance representing 5 percent ($37 million) of the total.

SECTION 4. OPTIONS AND PROGRESS IN EXPANDING COVERAGE

In September 2000, Vermont received an initial State Planning Grant (SPG) and a Supplemental SPG in September of 2003. All activities have been completed and all goals were achieved for the initial SPG. Vermont has made substantial progress in meeting the goals of the Supplemental SPG and anticipates that all activities will be completed prior to August 2005.

Insurer and health care provider workgroups were conducted in which each group's perceptions of public and private health care coverage was explored. Coverage options were identified, and simulations were developed to model the cost and impact of each of the various options on each

stakeholder group. Focus groups were then conducted with employers and uninsured Vermonters to market test the options. A tentative set of options was then selected by the Steering Committee and modeled. The options identified by the Steering Committee and considered under the initial SPG included the following:

1) Enhance outreach to increase enrollment in existing public programs.
2) Expand coverage by increase income eligibility levels.
3) Permit small employers and individuals living below 300 percent of the FPL to buy in to the current program, VHAP.
4) Facilitate expanded availability of coverage through employers and encourage purchase of employer-sponsored coverage through premium assistance.
5) Enact employer tax credits for small firms with low-income workers.
6) Develop low-cost coverage option for firms.
7) Implement a single payer program for Vermont

Vermont conducted an actuarial evaluation of each of the options identified by the Steering Committee. The evaluation focused on the impact of each option on the number of uninsured and the estimated cost of each option.

All of the options considered would result in some reduction in the number of persons without coverage. However, only the single-payer model would achieve universal coverage. Aside from the single-payer model, the option having the greatest potential impact on coverage was conducting outreach to enroll persons who are already eligible for VHAP or Dr. Dynasaur who have not yet enrolled.

It was estimated that an aggressive outreach program could raise the coverage level for children to 97.5 percent (from the current level of 95.8 percent) and the coverage level for adults in the state to 91.8 percent (from the current level of 90.2 percent). Under the outreach option, about 92.8 percent of all persons living below 300 percent of the FPL would be covered.

Analysis also indicated that higher levels of coverage could be achieved by combining certain policy options. For example, if Vermont were to adopt all of the VHAP expansion options discussed above (e.g., outreach with eligibility expansion for adults etc.) except the VHAP buy-in program, about 97.5 percent of children and about 93.6 percent of adults would be insured. Adding the VHAP buy-in program would increase coverage for adults to 94.5 percent.

Vermont could also adopt a combination of the options designed to expand private insurance coverage. For example, providing the employer tax credit (40 percent credit for firms with less than 25 workers) together with the low-cost insurance product would increase coverage for both children and adults. However, coverage would reach only 96.7 percent among children and 91.1 percent among adults.

Vermont determined that the most suitable direction was to examine and develop (based on examination findings) the following initiatives:

1) Premium Assistance
2) VHAP Buy-In/Lower Cost Insurance Products
3) Medical Savings Accounts

A summary of each of these initiatives with key findings (if appropriate) are provided below.

Premium Assistance

Findings from the initial SPG indicated that employers prefer to provide coverage for employees but face increasing financial pressures due to escalating health premiums. Additionally, national statistics indicate that as many as 40 percent of the uninsured adults have access to insurance through their employers. Vermont is examining options for using public resources to foster coverage through employer-sponsored plans.

The objectives of this initiative include the following:

- Maximize use of State resources
- Encourage private coverage, thereby supporting the private insurance market
- Encourage purchase of family coverage
- Foster independence and choice among enrolled members
- Reduce the number of uninsured Vermonters

Vermont is exploring options for subsidizing both the employee and employer shares of employer-sponsored coverage. Additionally, Vermont is assessing alternatives for administration of this initiative, with the objective of minimizing the resources necessary to administer the program. The Vermont Budget Act for the current year endorsed additional development of this option.

Findings

The findings from this initiative are still in process with a planned completion date prior to August 2005.

VHAP Buy-In

Research performed as part of the initial grant indicated that a major barrier for small employers who wish to offer coverage is the lack of a low-cost insurance product. Vermont evaluated options for making low-cost insurance options accessible to small employers. Among these options, Vermont further refined its "VHAP Buy-In" approach, whereby individuals and small employers may purchase coverage through Vermont's public program, VHAP. Objectives of the initiative included the following:

- Expand access to coverage for small employers, sole proprietorships and individuals by offering lower cost products

- Encourage private contribution for health care coverage
- Take advantage of existing public administrative functions (e.g., provider enrollment, claims processing)
- Reduce the number of uninsured Vermonters

Findings

Thorough modeling of the initiative in conjunction with Vermont's health insurance market revealed that implementing VHAP Buy-In would have several negative implications. A summary of each of these implications are provided below. The document "A Buy-in to the Vermont Health Access Program (VHAP) for Individuals and Small Employers: Cost and Coverage Impacts, Final Report, February 9, 2004" is included with this report as part of Appendix II.

Adverse Impact upon Providers

According to the design for VHAP Buy-In, reimbursement should "provide payments to providers at levels ten percent greater than levels paid under the Medicare program." This feature is singularly necessary in order to permit premiums to be set substantially lower than currently available in the commercial small group and non-group insurance markets ~ roughly 25 percent lower. However, these favorable premium rates result in a substantial cost shift to health care providers. The Buy-In program can only extend these lower premiums to its subscribers by paying hospitals 23 percent less than they receive from commercial insurers, while paying physicians 27 percent less. This amounts to a $27.9 million reduction in payments to Vermont health care providers. Thus, the Buy-In program assumes that providers will artificially subsidize the program. The model predicted that:

- 70-90 percent of the financial loss experienced by health care providers who participate in the VHAP buy-in program would eventually resurface as higher premiums in the commercial market.
- The cost of providing coverage to state employees would likely increase $2.4 million as a result of provider reimbursement shortfalls being passed along to other carriers.
- Spending by the federal government to provide health insurance coverage for its Vermont-based employees would also rise by $300,000.

Administrative Costs

It was determined that costs for administering the VHAP Buy-In program would be roughly the same as the administrative costs experienced by Blue Cross/Blue Shield of Vermont ~ between 14 percent and 18 percent of pure premium. This further supports the conclusion that the premium differential is primarily driven by lower provider reimbursement. The analysis also found that administrative costs at private insurers may actually increase as a consequence of spreading fixed administrative costs over a smaller privately-insured population.
Market Share Encroachment upon the Commercial Insurance Market

VHAP Buy-In could dramatically reduce the number of people purchasing coverage in three important insurance markets in the state:

1) Non-group market
2) Association health plans
3) Small group market

The model estimated that about 30 percent of those currently enrolled in these markets would shift to the VHAP Buy-in to take advantage of the lower premium. It is unclear whether the affected insurance markets would be viable with the loss of such a large portion of current enrollment. An enrollment loss of this magnitude could substantially reduce any economies of scale that exist in administering these insurance pools and greatly destabilize premiums by reducing the predictability of losses for such groups. This together with the increased cost-shift would increase private insurer premiums that could result in a loss of coverage among those who remain in the commercial markets. Loss of such a large portion of the market to the Buy-in could result in the withdrawal of the few commercial insurers that remain in Vermont's individual and small group markets.

Capital or Higher Premiums Required to Cover Initial Claims Reserve and Stop Loss Insurance

VHAP Buy-In would need to be capitalized from the outset or premiums would have to be recalculated upward to provide for:

1) Sufficient funds in a reserve fund to cover the cost of claims that the program will experience from its first day of operation – the reserve fund must also have sufficient capital to protect the program against unexpectedly high claims. It was estimated that the Buy-In program would require between $5.5 million and $40 million in upfront cash (depending upon the eligibility scenario) to indemnify the program against early expenses. Eventually, sufficient premium revenue would accumulate to capitalize its own reserve account – an amount equal to 2-3 typical month's worth of claims. However, the Buy-In program would be required to repay the money advanced at start-up.

2) Purchase of stop loss reinsurance – it is common practice for health insurers to purchase stop loss reinsurance to protect the plan against the incidence of very large claims

Modest Reduction in Uninsured Vermonters

It was determined that the vast majority of the enrollees in the Buy-In program would be persons migrating from existing commercial coverage. Depending upon the eligibility rules, somewhere between 7,200 and 9,600 of the enrollees would come from the ranks of the currently uninsured. However, this group of newly-insured individuals represents only 12-15 percent of the 61,700 Vermonters who are now uninsured. Even with the 25 percent reduction in provider payment rates, the premiums would continue to be unaffordable to many of the uninsured.
Disrupting Competitive Market Forces

Another concern of the introduction of the Buy-In program into the marketplace is the inequity that the program could cause between competing businesses. A substantial number of Vermont's small businesses have, despite the costs of doing so, elected to offer health insurance coverage to their employees. For some, this was a decision motivated by a sense of social responsibility. For others, it seemed like good business. They have calculated that offering health insurance is valued by their employees as an important fringe benefit. These employers have concluded that offering health insurance gives them a marketable advantage as they contend with their competitors for qualified workers and endeavor to retain those workers and reduce attrition.

Introduction of a government-sponsored health insurance program targeted at those very competitors who have thus far *not* chosen to offer health insurance to their workers robs those companies that *have* done so of their competitive advantage – indeed, places them at a *disadvantage* because their competitors will now be able to purchase health insurance coverage at a lower price!

Medical Savings Accounts

Vermont is exploring the use of Medical Savings Accounts (MSAs) to expand health care coverage in the State. One option under consideration includes public financing of MSAs as an option for extending health care to individuals eligible under Vermont's 1115 waiver, the Vermont Health Access Plan (VHAP) and the State Child Health Insurance Program (SCHIP).

Under a typical MSA arrangement, an individual (or employer) makes tax-free deposits to an MSA that then may be used to pay for medical expenses or insurance premiums. An MSA is typically coupled with a high-deductible, catastrophic policy; MSA funds are used to pay for routine services and deductibles, while the health insurer pays for expensive health services, if needed. If funds remain in the account at the end of the year, they may be carried-over for use in the subsequent year.

Vermont is examining the use of the MSA concept within a public program. For example, a member's monthly enrollment fees may be used to fund the MSA account; available MSA funds then would be accessed to pay for non-covered health benefits or cost sharing obligations.

Specific objectives of this initiative include the following:

- Enhance the role of the individual in the health care purchasing process
- Give individuals greater flexibility and control over how health care funds are spent
- Encourage individuals to be prudent healthcare purchasers
- Expand members' choice of insurance products
- Reduce the number of uninsured Vermonters

Findings

The findings from this initiative are still in process with a planned completion date prior to August 2005.

SECTION 5. CONSENSUS BUILDING STRATEGIES

Vermont's Steering Committee, consisting of representatives from the various stakeholder groups, met regularly and participated in planning and advising on the various research activities. Stakeholder groups included providers, employers and advocacy groups, as well as legislators from the Health and Welfare Committees of the House of Representatives and the Senate.

In addition to legislative representation, the following groups each sent a representative to the Steering Committee: the Bi-State Primary Care Association; the Vermont Business Roundtable; the Vermont Chamber of Commerce; the Commission on the Public's Health Care Values and Priorities; the Department of Banking, Insurance, Securities and Health Care Administration; the Vermont Agency of Hospital and Health Services; the Vermont Medical Society; the Vermont Coalition of Clinics for the Uninsured; the Vermont Program for Quality in Health Care; Legal Aid's Ombudsman Office; the Vermont Department of Health; Blue Cross and Blue Shield; the Agency of Human Services (AHS); and the Veteran's Hospital.

Because Steering Committee members represented a diverse group of stakeholders and were involved with health policy and other groups, one of their early activities was to identify other groups and projects related to the SPG. It was determined that the SPG would benefit from the findings of these other groups, and that the "whole was greater than the sum of the parts." Several Steering Committee members were also on the Governor's Blue Ribbon Commission.

Section 6. Lessons Learned and Recommendations to States

In order to understand related and contributing factors to insurance coverage, states need to devote research to gathering detailed data about insurance coverage including demographics, socioeconomic and employment characteristics.

Section 7. Recommendations to the Federal Government

The *Current Population Survey (CPS) Annual Demographic Survey* does not provide an adequate sample or sufficient detail to support in-depth analysis. If the CPS were fielded to a larger sample, included sufficient detail and state-specific questions, it might eliminate the need for individual states to have to field their own surveys.

End Notes

[1] Mills, R. and Bhandari, S. "Health Insurance Coverage in the United States: 2002." U.S. Census Bureau, September 2003. Available at: http://www.census.gov/hhes/www/hlthin02.html.

[2] Kaiser Family Foundation, State Health Facts Online, Medicaid and SCHIP Eligibility, available at http://statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?.

[3] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2001 Medical Expenditure Panel Survey-Insurance Component, Table IIB.2.a (2001). Available at: http://www.meps.ahrq.gov/MEPSDATA/ic/2001/Index201.htm.

[4] U.S. Census Bureau, Health Insurance Coverage: 2002, Detailed Tables, Table HI05. Available at: http://ferret.bls.census.gov/macro/032003/health/toc.htm.

[5] Vermont Department of Banking, Insurance, Securities and Health Care Administration, 2000 Vermont Family Health Insurance Survey. Employment and Health Insurance in Vermont: Summing it Up, January 2002. Available at http://www.bishca.state.vt.us/HcaDiv/Data_Reports/SurveyVTFamilyHealth2000/SurveyIndex2000.htm.

[6] "ERISA" stands for the Employee Retirement Income Security Act of 1974.

[7] Vermont Department of Banking, Insurance, Securities and Health Care Administration, 2000 Vermont Family Health Insurance Survey. Table: Source of Health Insurance, All Vermont Residents. Available at http://www.bishca.state.vt.us/HcaDiv/Data_Reports/SurveyVTFamilyHealth2000/SurveyIndex2000.htm.

[8] *2002 Employer Health Benefits Survey*. Kaiser Family Foundation/Health Research and Educational Trust, September 2002. Available at: http://www.kff.org/content/2002/3251/.

Appendix I: Baseline Information

Population:	616,592 (2002)
Number and percentage of uninsured (current and trend):	Number: 62,892 (2002) Percentage: 10.2% (2002)
Average age of population:	37.9 years (2002)
Percent of population living in poverty (<100% FPL):	12% (Kaiser Family Foundation, State Data 2001-2002)
Primary industries:	Trade/Transportation/Utilities; Education – Health Services; Manufacturing; Leisure/Hospitality (Vermont Department of Employment and Training, 2003)
Number and percent of employers offering coverage:	
Number and percent of self-insured firms:	
Payer mix:	
Provider competition:	
Insurance market reforms:	
Eligibility for existing coverage programs (Medicaid/SCHIP/other):	*Vermont Health Assistance Programs Income Guidelines (Annual)* http://www.dsw.state.vt.us/districts/ovha/pig2004annual.pdf
Use of Federal waivers:	Yes

Appendix II

A Buy-in to the Vermont Health Access Program (VHAP) for Individuals and Small Employers: Cost and Coverage Impacts, Final Report
Office of Vermont Health Access
February 9, 2004

Frequency Asked Questions about Health Coverage and the Vermont Insurance Market
Department of Banking, Insurance, Securities and Health Care Administration
January 2004
http://www.bishca.state.vt.us/HcaDiv/Data_Reports/healthinsurmarket/FAQs_healthmarket.pdf

Vermont Health Care Expenditure Analysis
Department of Banking, Insurance, Securities and Health Care Administration
December 2003
http://www.bishca.state.vt.us/HcaDiv/Data_Reports/expenditure_analysis/hc_expend_anal_forecast_02-06.pdf

Employment-based Health Insurance in Vermont: Summing It Up
Department of Banking, Insurance, Securities and Health Care Administration
January 22, 2002
http://www.bishca.state.vt.us/HcaDiv/Data_Reports/SurveyVTFamilyHealth2000/EmployInsur012202.pdf

Family Health Insurance Survey
Department of Banking, Insurance, Securities and Health Care Administration
2000
http://www.bishca.state.vt.us/HcaDiv/Data_Reports/SurveyVTFamilyHealth2000/SurveyIndex2000.htm

Vermont Health Assistance Programs Income Guidelines (Annual)
Office of Vermont Health Access
2004
http://www.dsw.state.vt.us/districts/ovha/pig2004annual.pdf