Covering VHAP and SCHIP Enrollees under a Voucher Model:

Program Design and Actuarial Analysis

Prepared for:
The Office of Vermont Health Access

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EXECUTIVE SUMMARY

The purpose of this paper is to introduce an 1115 waiver concept to provide vouchers for the purchase of health insurance to people who are currently eligible under the Vermont Health Access Plan (VHAP) and the State Children's Health Insurance Program (SCHIP). Under this waiver, beneficiaries would receive a voucher that can be redeemed with participating private health plans for a policy with specified benefits and co-payment requirements. Beneficiaries would also receive a second voucher to cover a portion of the deductibles and co-payments under the policy.

The amount of these vouchers would vary with beneficiary income such that total beneficiary cost-sharing (i.e., premiums plus co-payments) would not to exceed 7.5 percent of family income for adults and 5.0 percent of family income for children. The program would be mandatory for all VHAP and SCHIP enrollees (24,286 beneficiaries), which includes 21,059 adults and 3,227 children. These eligibility groups include:

- **VHAP Adults:** Includes parents with incomes between about 60 percent of the federal poverty level (FPL) and 185 percent of the FPL and all able-bodied non-custodial adults with incomes below 150 percent of the FPL.
- **SCHIP Children:** Children with incomes between 225 percent of the FPL and 300 percent of the FPL.

To be eligible to participate in the program, insurers must be certified by the Commissioner of Banking, Insurance, Securities, and Health Care Administration (BISHCA) as offering a plan that provides the required benefits and conforms to various requirements including: an administrative cost ceiling of 15 percent; and provider reimbursement at 110 percent of Medicare levels.

Purpose of Voucher Waiver

The purpose of the voucher program is to move Medicaid and SCHIP participants into the mainstream of private health insurance coverage while also creating financial incentives for beneficiaries that promote cost containment. The waiver would do this by providing a choice of private health plans to beneficiaries with cost-sharing requirements similar to those found in existing private health plans.

The program is also designed to reduce cost-shifting to private payers by reimbursing providers at levels equal to 110 percent of Medicare payment levels for voucher enrollees. As discussed below, this represents an average increase in payments per beneficiary of about 24 percent. This would greatly reduce shortfalls in provider payment (i.e., the difference between payments and costs), which is intended to result in less cost-shifting to privately insured patients. This would probably be reflected in slowed growth in private health insurance premiums.

The program also creates incentives for participants to be more cost conscious when using health services. Provider co-payments for VHAP enrollees would increase by an average of about 88

percent and co-payments would be introduced for most health services received by SCHIP children.[1] Participants are also encouraged to select lower-cost health plans by basing the voucher payment amount on the lowest premium charged for waiver certified coverage by the private health plans that decide to participate in the program.

Impact on Program Cost

Based upon actuarial analysis of program costs and enrollment under this program, we estimate that state program costs for this population under the current program in 2003 would be about $152.24 per-member per-month (PMPM) for VHAP adults and $47.60 PMPM for SCHIP children.[2] This monthly cost is equal to total benefits costs less the beneficiary co-payments and premium contributions.

The voucher model would affect program costs in several ways (***Figure ES – 1***). Costs would increase for this population under the waiver due to the use of higher provider payment levels (about 24 percent increase). Costs would also increase due to the added cost of administration under private health plans, which we estimate to be about 15 percent. However, these increases in program costs would be largely offset by the increase in co-payments and premium contributions under the program.

Figure ES - 1
Change in State Cost Under the Voucher Program
On a Per-Member Per-Month (PMPM) Basis in 2003

	VHAP	SCHIP
Net Cost to State Under Current Policy		
Total Premium [a/]	$155.88	$78.85
Beneficiary Premium Contribution	($3.64)	($31.25)
Net Cost – Current Program	$152.24	$47.60
Impact of Voucher Program Provisions on Total Premium Cost		
Current total Premium	$155.88	$78.85
Reimbursement Increase	$35.96	$20.25
Private administration	$33.85	$17.54
Increased co-payments	($44.50)	($28.76)
Selection Effect	$20.60	$3.28
Net PMPM costs	$201.79	$91.16
Net Cost to State Under Voucher Program		
Offset for beneficiary premium share	($20.14)	($40.00)
Co-payment voucher	$38.36	$13.27
Net payment to insurer	$220.00	$64.43
Change in Net Cost to State Under Voucher Program		
Net Cost to State – Current Policy	$152.24	$47.60
Net Cost to State – Voucher Program	$220.00	$64.43
Increase (Decrease) in Net Cost to State	$67.76	$16.82

a/ Total benefits cost. Excludes beneficiary co-payments and premium contributions.
Source: Lewin Group Estimates based upon VHAP and SCHIP program data.

[1] VHAP adults have co-payments of: $7.00 for physician visits; $25.00 for most hospital outpatient services; $50.00 per inpatient stay; and 50 percent for prescription drugs up to a maximum cost-sharing amount for drugs of $750 per year. SCHIP enrollees face only the prescription drug co-payment.
[2] Reflects recent changes in benefits under the VHAP program.

As discussed below, the increase in premiums and co-payments for this population would discourage some persons from enrolling in VHAP and SCHIP. Average premium payments for VHAP adults would increase from about $5.00 PMPM to an average of about $20.00 PMPM under the program.[3] For SCHIP children, monthly premiums would increase from about $31.00 per-child (i.e., $50 per family) to about $40.00 per-child. While this reduces aggregate program costs, the people who remain with the program are expected to be those most in need of health care, which has the effect of increasing the average cost per enrollee under the program by about 13 percent.[4]

We estimate that the net cost of the program to the state would rise to about $220.00 PMPM for adults and $64.42 PMPM for children. This is an increase of about $67.76 PMPM for VHAP adults and about $16.82 PMPM for SCHIP children.

Impact on Program Enrollment

We estimate that VHAP and SCHIP enrollment would decline in response to the increased premiums under the program. As discussed above, premiums would increase from an average of about $5.00 PMPM for VHAP adults $31.00 PMPM for SCHIP children to an average of about $20.00 PMPM for adults and $40.00 PMPM for children. Studies have shown that premium payments can reduce participation among public health benefits program by a third or more, depending upon the amount of the premium. Based upon this research, we estimate that the increase in premiums under the program would reduce enrollment by about 2,933 people, which is about 12 percent of current program enrollment.

We estimate that despite this reduction in enrollment, voucher program costs would exceed budgeted spending for the VHAP and SCHIP population by about $10.2 million in 2003 (***Figure ES – 2***). To maintain budget neutrality, the state would need to implement enrollment caps and waiting lists, which would result in an additional reduction in enrollment of about 4,313 people. This would bring the total reduction in enrollment of 7,246 people (29.8 percent of current VHAP and SCHIP enrollment).

The reduction in enrollment would include about 725 children and about 6,521 adults (***Figure ES – 3***). About 44 percent of these disenrollees would be persons with incomes below the FPL.

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[3] The premium for the current VHAP program is paid each six months. We averaged these premiums over six months to obtain a monthly premium estimate for the VHAP population.

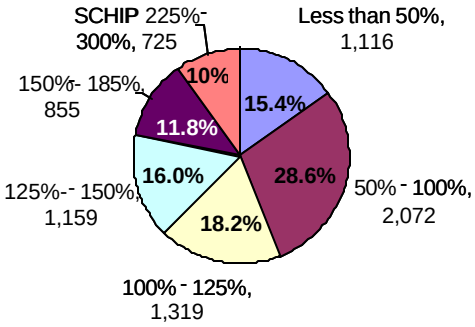
[4] This is typically referred to as the "selection effect."

Figure ES-2
Five Year Cost and Enrollment Projections for the Waiver Population

	VHAP/SCHIP Enrollment b/			VHAP/SCHIP Costs (in millions)		
		With Waiver			With Waiver	
	Current VHAP/SCHIP a/	Without Enrollment Cap	With Enrollment Cap c/	Current VHAP/SCHIP a/	Without Enrollment Cap	With Enrollment Cap c/
2003	24,286	21,353	17,040	$40.3	$50.5	$40.3
2004	24,529	21,567	17,210	$44.7	$56.0	$44.7
2005	24,774	21,782	17,383	$49.6	$62.1	$49.6
2006	25,022	22,000	17,956	$55.0	$70.0	$55.0
2007	25,272	22,200	17,323	$61.0	$76.4	$61.0

a/ Based upon OVHA projections for 2003 indexed to population growth and cost growth under the program.
b/ Reflects voluntary dis-enrollment in response to premium increase.
c/ Assumes that enrollment is capped so that total costs under the waiver are no greater than what would have been spent for the VHAP and SCHIP population under current policy.
Source: Lewin Group estimates based upon OVHA data.

Figure ES - 3
Reduction in Enrollment by Income as a Percent of FPL



Total Enrollment Reduction = 7,246

Source: Lewin Group estimates.

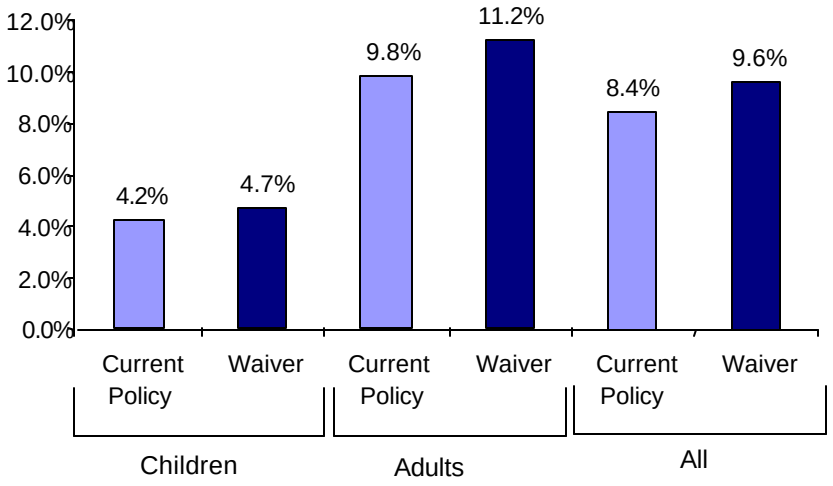
Impact on Number of Uninsured

The Vermont Health Insurance Survey for 2000 indicated that about 8.4 percent of all Vermonter's (51,400 people) are without health insurance. The percent uninsured is 4.2 percent for children and 9.8 percent among adults (***Figure ES-4).*** The number of uninsured is likely to increase due to the disenrollment resulting from the voucher program

Few of those who are dis-enrolled from the VHAP and SCHIP programs are expected to obtain coverage elsewhere. This would increase the number of uninsured in the state by about 14.2 percent. The number of uninsured in Vermont would increase from the current estimate of

51,400 persons to about 58,700 persons. The percentage of Vermonters who are uninsured would increase from 8.4 percent to 9.6 percent under the voucher program. The percentage of children without coverage would increase from its current level of 4.2 percent under the current law to about 4.7 percent under the voucher. The percentage of adults without coverage would increase from about 9.8 percent under current law to about 11.2 percent under the voucher.

Figure ES-4
Percent Uninsured in Vermont With and Without the VHAP/SCHIP Waiver



Source: Vermont Division of Health Care Administration, BISHCA 2000 Vermont Family Insurance Survey

Conclusion

The voucher program would increase the net state cost of covering the VHAP and SCHIP programs, despite the increase in premium contributions and co-payment requirements under the program. Our analysis indicates that the cost of increasing provider reimbursement levels and the cost of private insurer administration of benefits would be greater than the savings from increased beneficiary cost sharing.

Enrollment in the VHAP and SCHIP programs would decline by about 2,933 persons due to the increase in beneficiary cost-sharing under the program. However, despite this decline in coverage, the state would need to enforce and enrollment cap to keep costs within the amounts budgeted for these programs. When these disenrollments are counted, program enrollment would be reduced by about 7,246 people (about 29.8 percent), including 725 children and about 3,118 people living below the FPL.

This loss of enrollment would result in a 14.2 percent increase in the number of persons in Vermont who are uninsured. This reduction in coverage would lead to an increase in uncompensated care expenses for providers that would largely offset the increase in provider reimbursement levels under the waiver. The loss of coverage would also decrease the use of primary care, which could result in higher system costs in the long run.

SUMMARY AND INTRODUCTION

The purpose of this paper is to introduce an 1115 waiver concept to provide vouchers for the purchase of health insurance to people who are currently eligible under the Vermont Health Access Plan (VHAP) and the State Children's Health Insurance Program (SCHIP). Under this waiver, beneficiaries would receive a voucher that can be redeemed with participating private health plans for a policy with specified benefits and co-payment requirements. Beneficiaries would also receive a second voucher to cover a portion of the deductibles and co-payments under the policy. The program would be mandatory for all VHAP and SCHIP enrollees (24,286 beneficiaries), which includes 21,059 adults and 3,227 children.

The amount of these vouchers would vary with beneficiary income such that total cost-sharing (i.e., premiums plus co-payments) would not to exceed 7.5 percent of family income for adults and 5.0 percent of family income for children. This approach would increase average premium payments for the VHAP population from their current level of about $5.00 per-member per-month (PMPM) to an average of about $20.00 PMPM under the program. For SCHIP children, monthly premiums would increase from its current average of about $31.00 per-child (i.e., $50 per family) to about $40.00 per-child under the voucher program.

To be eligible to participate in the program, insurers must be certified by the Commissioner of Banking, Insurance, Securities, and Health Care Administration (BISHCA) as offering a plan that provides the required benefits and conforms to various requirements. Health plan premiums would be regulated so that insurer administrative costs may not exceed 15 percent of benefit payments under the program. Plans also would be required to reimburse providers at 110 percent of Medicare payment levels, which is an increase in reimbursement for this population of about 24 percent.

As an incentive to control costs, VHAP would provide a voucher equal to the premium for the lowest-cost certified health plan in the state, less the beneficiary premium contribution requirement. Participants would be required to pay the full incremental cost of enrolling in a more costly plan. Also, to avert an increase in total program costs, the waiver design would allow the commissioner to implement enrollment limits and waiting lists when costs are expected to exceed budgeted levels.

The voucher model would affect program costs in several ways. Costs would tend to increase for this population due to the use of higher provider payment levels (about 24 percent increase) and the added cost of administration under private health plans (estimated to be 15 percent). These increases in program costs would be largely offset by the increase in co-payments and premium contributions under the program. Moreover, the increase in premiums and co-payments for this population would discourage some persons from enrolling resulting in savings attributable to reduced enrollment.

In this analysis, we estimate the number of persons who would be covered under the voucher program and the cost of providing the benefits called for under the proposal. We also estimate

the impact of the Waiver on the number of persons in the state who do no have health insurance. Our analysis of the waiver proposal is presented in the following sections:

- Purpose of Waiver;
- Background on Current Program;
- Waiver Design;
- Health Plan Certification and Cost Control Incentives;
- Actuarial Analysis and Budget Neutrality Considerations;
- Quality and Access; and
- Medicaid Provisions to be Waived.

A. Purpose of Waiver

The purpose of the voucher program is to move Medicaid and SCHIP participants into the mainstream of private health insurance coverage while also creating financial incentives for beneficiaries that promote cost containment. The waiver would do this by providing a choice of private health plans to beneficiaries with cost-sharing requirements similar to those found in existing private health plans.

The program is designed to reduce cost-shifting to private payers by reimbursing providers at levels equal to 110 percent of Medicare payment levels for voucher enrollees. As discussed above, this represents an average increase in payments per beneficiary of about 24 percent. This would eliminate shortfalls in provider payment (i.e., the difference between payments and costs), resulting in less cost-shifting to privately insured people, which would probably take the form of slower premium growth.

The waiver would also create incentives for participants to moderate their use of health care. The plan would increase co-payments at the point-of-service for health services by an average of about 68 percent for VHAP adults, who currently have co-payments averaging about $25 PMPM. SCHIP children, who currently have co-payment requirements for prescription drugs only, would now face co-payments for other services up to a maximum of about $26 PMPM.

In addition, the voucher proposal includes incentives for beneficiaries to seek out the lowest cost health plans, which would also help moderate the growth in costs over-time. As discussed above, the amount of the premium voucher would be equal to the premium for the lowest cost qualifying health plan available in the state (less beneficiary premium requirement). Beneficiaries would be required to pay the full incremental cost of enrolling in a more costly plan. This would provide incentives for plans to compete for enrollment on the basis of price.

This waiver concept could serve nationally as a model for moving the Medicaid population to the mainstream of health care through private health plans. Some of the key hypotheses that would be tested under this proposed demonstration include:

- ***The effectiveness of vouchers as a mechanism to integrate public and private insurance programs***. The plan would use public dollars to purchase private insurance thereby encouraging public and private cooperation and integration.

- ***The participation of eligible people under changes in cost sharing, administration and delivery systems***. The waiver design would encourage beneficiaries to become self-sufficient in that they will have a choice of plans and be responsible for choosing a plan and maintain cost sharing payments in excess of voucher amounts.

- ***The impact of enhanced provider payments on provider participation and cost-shifting.*** Enhanced provider payments are likely to increase provider participation, which may increase access, minimize cost-shifting to private payers. This could mitigate increases in private health premiums attributable to the cost-shift.

- ***The willingness of insurers to participate in the program and barriers in recruiting plans.*** It is unclear how insurers would respond to the waiver design. They have incentives to participate and compete for enrollees and premium payments; however, they have disincentives related to additional administrative burdens.

- ***The ability of free market forces and managed competition to control costs.*** The plan fosters competition among plans to reduce costs and attract enrollees since they have a choice of certified plans.

- ***Overall program costs.*** There are a number of factors that are likely to increase and decrease costs under the waiver design.

- ***Quality and access to care.*** Quality would be measured and monitored by quality assurance contractors as in the current VHAP program. Access to providers is likely to be expanded due to enhanced provider payment requirements.

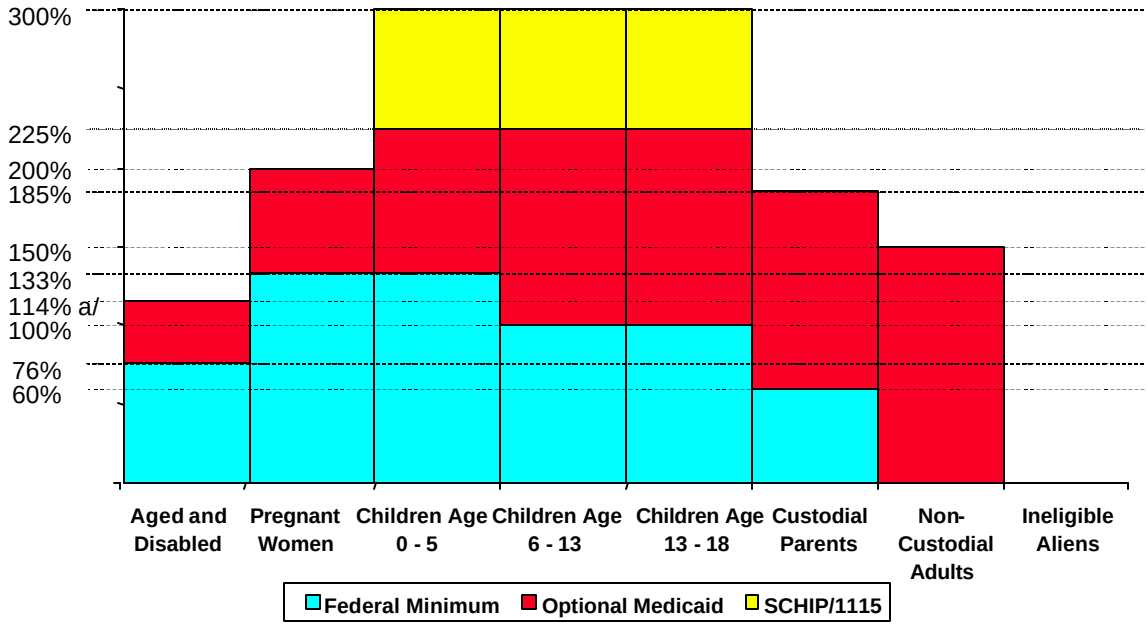
B. Background / Current Program

The income eligibility levels under the Vermont VHAP program are among the highest in the nation. 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 federal poverty level (FPL) compared with the federal minimum of 76 percent of the FPL (92 percent of the FPL for married couples).[5] Pregnant

[5] 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.

women are covered through 200 percent of the FPL, and all children are eligible through 300 percent of the FPL. [6]

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. [7] The state also covers non-custodial adults through 150 percent of the FPL under an 1115a Medicaid waiver program. There are only six other states with an 1115a waiver to cover non-custodial adults. [8]

VHAP is a waiver program covering parents and caretaker relatives with incomes in excess of 60 percent of the FPL and all non-custodial adults through 150 percent of the FPL. Originally, the VHAP program enrolled participants in a selection of HMOs. However, after Kaiser health plan

[6] 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.
[7] 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 (also known as the TANF) income eligibility levels.
[8] There are seven 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).

exited the Vermont market, the program was converted to a primary care case management (PCCM) program.

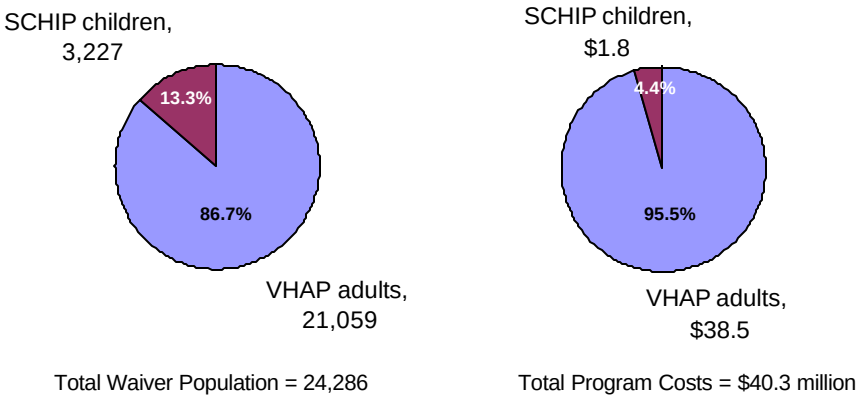
Participants in the current VHAP program are required to make a premium contribution and face co-payments at the point-of-service. The premium is paid semi-annually. It ranges from $10 per six-month period to $50 per six-month period depending upon income. There is no premium for persons with incomes below 50 percent of the FPL. Co-payments for adults under the current VHAP program are:

- $7.00 per Physician Visit;
- $25.00 per Hospital Outpatient Visit;
- $50.00 per Inpatient Visit;
- $25.00 per Emergency Room Visit;
- $60.00 per Non-emergency Visit to an Emergency Room; and
- 50% Percent co-payment for prescription drugs up to a maximum cost-sharing limit of $750 per year.

Under the current SCHIP program, premiums are required for all children. The premium is $50 per-family per-month, regardless of the number of children (premium averages about $31 per child). There is a 50 percent co-payment for prescription drugs up to a maximum cost-sharing limit of $750 per year (same as for VHAP enrollees). There are no other co-payments for SCHIP children.

In 2003, there would be about 24,286 persons enrolled in VHAP and SCHIP. Total costs for these two groups are estimated to be $40.3 million in 2003 ***(Figure 2)***. VHAP adults account for about 86.7 percent of enrollment and about 95.3 percent of total costs for the VHAP and SCHIP programs combined.

Figure 2
Enrollment and Expenditures for the Waiver Population under Current Law in 2003[a/]



a/ Includes program cost less premium payments received.
Source: Lewin Group estimates using program data.

C. Waiver Design

In this section we describe the key elements of the voucher program from the perspective of the beneficiaries. This includes the calculation of the voucher amounts for premiums and co-payments. The structure of the program is presented in the following sections:

- Eligibility;
- Benefits Package;
- Estimated Premium and Voucher Amount; and
- Co-payment Voucher Amount.
- Provider Payments.

1. Eligibility

The waiver population would include adults covered under VHAP and children covered under SCHIP. This includes custodial parents with incomes between the AFDC eligibility level (i.e., about 60 percent of the federal poverty level (FPL)) and 185 percent of the FPL, and all non-custodial adults (excluding disabled) below 150 percent of the FPL. SCHIP eligible children include those with incomes between 225 percent and 300 percent of the FPL. These individuals would be designated as the "waiver population."

Persons who qualify for home and community based waivers or the traumatic brain injury (TBI) waiver program would not be included in the waiver population. There would be no expansion in eligibility beyond current eligibility levels.

According to previous analysis done in Vermont, up to 39 percent of all uninsured people in the state are actually eligible for traditional Medicaid, VHAP, or Dr. Dynasaur, but have not enrolled.[9] While eligibility for the program would remain the same, the waiver is likely to change program participation rates due to changes in cost sharing amounts. These changes are discussed in the actuarial analysis section below.

2. Benefits Package

Participants would receive a voucher that can be redeemed with private insurers for the purchase of a specified benefits package. Covered services would include the same services covered for adults under the existing VHAP program except transportation, home and community-based waivers for mental health and retardation, and traumatic brain injury (TBI) services. The VHAP benefits package is designed to be comparable to comprehensive commercial health benefits packages offered in Vermont.

SCHIP children also would be covered under this benefits package. The package would meet the federal requirement that it be at least actuarially equivalent to the state employees health benefits package. However, the plan would require waivers to cost-sharing limits that are discussed below.

3. Estimated Premium and Voucher Amount

As discussed below, we estimate that the monthly premium for this benefits package would be $201.79 for adults and $91.16 for children (before beneficiary premium contribution), assuming provider payment rates at 110 percent of Medicare levels (before premium contributions). This estimate is based upon VHAP program data for adults during the July 1, 2000 through June 30, 2001 period. The derivation of these estimates is discussed in more detail below.

Beneficiaries would receive a voucher in an amount sufficient to pay the full premium for the lowest cost plan in the state, less the amount the premium that beneficiaries are required to pay. The beneficiary premium amount is calculated not to exceed 4 percent of family income. The premium contribution amounts for the waiver population (i.e., VHAP and SCHIP) are presented in ***Figure 3*** under current law and under the voucher model.

The beneficiary contribution would average about $20.14 PMPM for adults and about $40.00 PMPM for children. Thus, the premium vouchers (total premium less beneficiary contribution) would on average be $181.64 PMPM (i.e., $201.79 – $20.14) for adults and $51.16 PMPM (i.e., 91.16 - $40.00) for children.

[9] "Expansion of Health Insurance Coverage to Uninsured Vermonters", (report for the HRSA state planning grant), The Vermont Agency of Human Services, October 29, 2001.

Figure 3
Premium Contribution Amounts for the Waiver Population Under Current Policy and Under the Voucher Program

	Current Premium		Voucher Premium	
Income as a Percent of FPL	**Semi-Annual**	**Monthly**	**Semi-Annual**	**Monthly**
VHAP Adults				
Below 50%	none	none	none	none
50% - 75%	$10	$1.70	$50	$8.45
75% - 100%	$15	$2.50	$100	$16.70
100% - 125%	$30	$5.00	$200	$33.30
125% - 150%	$40	$6.70	$240	$40.00
150% - 175%	$50	$8.33	$275	$46.00
175% - 185%	$50	$8.33	$320	$53.30
SCHIP Children				
225% - 300%[a/]	$186	$31.00	$240	$40.00

a/ The current premium for children in SCHIP is $50 per month per family, which equals and average premium per child of about $31 per month.
Source: Lewin Group Analysis of VHAP and SCHIP program data.

The insurer would be responsible for collecting the beneficiary premium contribution. The health plan would be permitted to terminate coverage for non-payment of the beneficiary hare of the premium.

4. Co-payment Voucher Amounts

The waiver would increase co-payments at the point-of-service for VHAP beneficiaries. It would also implement co-payments for SCHIP children, who now face co-payments for prescription drugs only. Under the voucher model, the plan would have the following cost-sharing requirements:

Deductible	$500
Co-Payments	20% for next $5,000
Out-of-pocket Maximum	$1,500

In addition, the program would retain the cost-sharing requirement for prescription drugs under the current program. These include a 50 percent co-payment up to a maximum out-of-pocket limit for prescription drugs of $750 per year. Cost-sharing would be administered separately for each person in a family.

The program would also provide a voucher to cover out-of-pocket payments for covered health services. The voucher would be set such that adults do not spend more than 3.5 percent of their income on out-of-pocket payments. The voucher for children would be set so that out-of-pocket spending does not exceed 1.0 percent of family income. The maximum allowable co-payment amounts under current law and the voucher proposal are presented in ***Figure 4***.

Figure 4
Average Co-Payment Amounts Under Current Policy and Under The Voucher Model [a/]

	Current Co-payments [b/]		Voucher Co-payments	
Income as a Percent of FPL	**Annual Amount**	**Monthly Amount**	**Annual Amount**	**Monthly Amount**
VHAP Adults				
Below 50%	$300	$25	$324	$27
50% - 75%	$300	$25	$324	$27
75% - 100%	$300	$25	$324	$27
100% - 125%	$300	$25	$440	$37
125% - 150%	$300	$25	$540	$45
150% - 175%	$300	$25	$624	$52
175% - 185%	$300	$25	$804	$67
SCHIP Children				
225% - 300%	$72	$6	$312	$26

a/ Estimates include co-payments for prescription drugs, which do not change under the proposal.
b/ Amounts estimated from program data. Assumed to be the same across income groups.
Source: Lewin Group analysis of VHAP and SCHIP program data.

These provisions are set so that the combined amount of spending for premiums and co-payments would not exceed 7.5 percent of income for adults and 5.0 percent of income for children.

The co-payment amounts under this proposal would be higher than under current law. Under the current co-payment schedule, co-payments average about $25 per month for VHAP beneficiaries at all income levels. Monthly co-payments would increase to between $27 for persons living below the FPL to about $67 for adults with incomes over 175 percent of the FPL. SCHIP children, who now face co-payments for prescription drugs only, would have co-pays averaging about $26 per month under the voucher model.

The health plans would be responsible for administering the co-payments. Providers would submit claims to the insurer for the full amount. The insurer would pay the provider the allowed charge (i.e., 110 percent of Medicare) less the amount of the beneficiary's required co-payment. The provider would then be responsible for billing and collecting the beneficiary co-payment amount. However, total provider billings for covered services could not exceed the allowable charge for each service.

D. Provider Payments

Payment levels for health care providers in Vermont have been a subject of considerable study. In Vermont, Medicaid payment rates for hospitals, physicians and other providers are well below Medicare payment amounts, which are themselves up to 20 percent less than private payments for comparable services. This disparity in payments often causes providers to increase their charges to privately insured patients to recover payment shortfalls for publicly insured people.

This process of shifting costs to private payers, known as cost-shifting, results in higher private insurance premiums for private insurance purchased by employers and individuals.

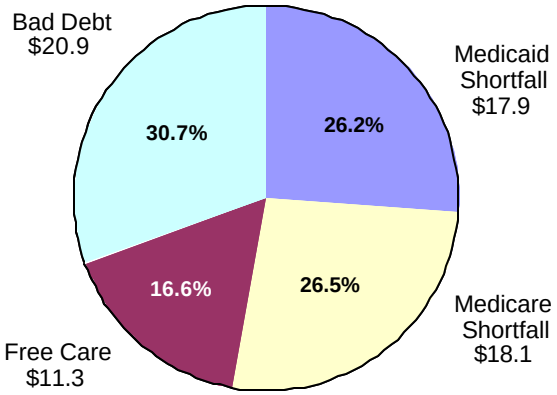
Under the voucher waiver, the insurer must agree to reimburse providers at 110 percent of Medicare levels for services provided under these plans. These increases in provider reimbursement under public programs would reduce cost-shifting resulting in lower private payer costs (typically in the form of slower cost growth). However, even at these higher payment levels, payments would continue to be about 10 percent less than private payer rates.

In this section, we present the available information on Medicaid payment levels for hospitals and physicians and the level of cost-shifting in the current Vermont Health care system.

1. Hospitals

Due to low payment rates for Medicare and Medicaid, bad debt and requirements to provide charity care, hospital revenues for these people typically are less than the average cost of providing these services. Hospitals recover this shortfall in reimbursement by increasing charges to private payers. The total amount of costs that are shifted to private payers was about $68.2 million in 2001 (***Figure 5***).

Figure 5
Hospital Cost-Shift by Source of Shortfall in 2001 (in millions)



Total Hospital Cost Shift = $68.2 million

Source: Lewin Group estimates.

Analyses show that using current payment rates, Medicaid/VHAP program accounts for about 26.2 percent of the hospital cost-shift in Vermont. Medicare accounts for 26.5 percent of the cost-shift, with charity care accounting for only about 16.6 percent. The largest share of the hospital cost-shift is attributed to bad debt, which is typically composed of unpaid coinsurance amounts for insured people ***(Figure 5).***

According to the Medicare Payment Advisory Commission's (MedPAC) state-by-state analysis of hospital private payment-to-cost ratios, Vermont has a payment-to-cost ratio of 122.4, indicating that private payments are higher than costs for Vermont hospitals. Vermont ranks 28th in the nation, and has a higher payment-to-cost ratio than the United States average (112.3).

Private payment-to-cost ratios are not consistently high across all the New England states. Connecticut, Massachusetts, and Rhode Island have low private payment-to-cost ratios (106.9, 96.4, and 92.4 respectively). In fact, Rhode Island and Massachusetts have the lowest private payment-to-cost ratios in the United States, with Rhode Island ranking 1st and Massachusetts ranking 2nd in the nation. In contrast, Maine, New Hampshire, and Vermont have high private payment-to-cost ratios (139.1, 122.5, and 122.4 respectively). Overall, 4 out of the 6 (Connecticut, Maine, New Hampshire, and Vermont) New England states have higher private payments relative to costs ***(Figure 6)*****.**

Figure 6
Hospital Private Payment-to-Cost Ratios by State, 1999

Rank	State	Payment-to-Cost Ratio	Rank	State	Payment-to-Cost Ratio
1	RI	92.4	**26**	FL	122.1
2	MA	96.4	**27**	OK	122.3
3	NY	96.9	**28**	**VT**	**122.4**
4	PA	100.9	**29**	NH	122.5
5	WA	105.2	**30**	NC	124.8
6	MI	106.2	**31**	WI	125.4
7	CT	106.9	**32**	KY	125.6
8	AZ	108.3	**33**	ND	127.5
9	MD	109.0	**34**	IN	128.7
10	OR	109.9	**35**	IA	129.4
11	AL	110.8	**36**	KS	129.9
12	MO	111.4	**37**	NE	130.1
13	CA	112.6	**38**	ID	131.0
14	OH	112.6	**39**	VA	131.4
15	CO	112.8	**40**	MT	133.0
16	NM	113.9	**41**	WV	133.6
17	NJ	114.1	**42**	GA	133.7
18	MN	114.9	**43**	AR	133.9
19	HI	115.3	**44**	SD	136.6
20	TN	117.5	**45**	ME	139.1
21	IL	119.9	**46**	SC	142.6
22	UT	120.3	**47**	AK	143.2
23	NV	120.4	**48**	WY	143.4
24	DE	120.7	**49**	MS	147.2
25	TX	121.9	**50**	LA	166.5
All Hospitals	**(Weighted Average)**	**112.3**			

Source: Medicare Payment Advisory Commission (MedPAC), 2001

2. Physicians

Medicaid and VHAP payment rates for services provided by physicians and other providers are typically lower than under both Medicare and private health plans. For example, a recent study conducted by the Urban Institute showed that, nationwide, payment rates for 22 commonly provided services under Medicaid were on average equal to about 64 percent of Medicare

payment rates for the same services.[10] Private payer rates for these services also can be greater than Medicare rates by 20 percent or more. Thus, the disparities in payment levels under Medicaid are quite substantial.

Physician payment rates for the VHAP/SCHIP population in Vermont are equal to about 69 percent of Medicare payment rates for the state. This is greater than the national average of 64 percent, and the New England average of 63 percent. It should be noted that Vermont's Medicare payment rate is one of the lowest in the country. Payment rates as a percentage of Medicare rates in New England states were highest in Massachusetts ***(Figure 7).***

Figure 7
Summary Comparison of Medicaid Payments for Selected Non-Hospital Services [a/]

	Percentage Difference from National Average [b/]	Medicaid Payments as a Percentage of Medicare Payments
Vermont	**10%**	**69%**
New England	7%	63%
New Hampshire	21%	67%
Maine	-4%	66%
Rhode Island	-33%	44%
Connecticut	51%	64%
Massachusetts	-2%	71%
U.S. Average	**N/A**	**64%**

a/ Estimates based upon a comparison of rates for 22 widely performed procedures.
b/ Index is equal to the ratio of average Medicaid payments in each state to average Medicaid payments nationally.
Source: Norton, Stephen, "Recent Trends in Medicaid Physician Fees, 1993 - 1998," Discussion paper, Urban Institute, September, 1999.

While Medicaid payment rates are low compared to other payers, the Medicaid payment levels in Vermont are actually greater than in most states. The Urban Institute study showed that payment rates in Vermont are about 10 percent higher than the national average. By comparison, payment rates in New England states are on average 7 percent greater than the national average. These co-payments are larger than the amounts permitted under current law. ***Figure 8*** presents estimates of the cost of increasing Vermont Medicaid physician payment rates to Medicare levels for 2000.

[10] Stephen Norton, "Recent Trends in Medicaid Physician Fees, 1993-1998", Urban Institute, Discussion Paper, September 1999.

Figure 8
The Cost of Adjusting Physician Payments under Medicaid to Medicare Levels

	OVHA ANALYSIS CY 2000							
Specialty	Billed Amount	Allowed Amount	Allowed to VMS ratio	Adjusted Medicaid at Medicare rate	Medicare as % of Charges	Medicaid Allowed % of Charges	Medicaid Allowed as % of Medicare	Amount necessary to get Medicaid to Medicare
General Practice	$33,085,392	$11,093,447	0.287	$16,094,122	48.6%	33.5%	68.9%	$5,000,676
Obstetrics/Gynecology	$7,008,822	$3,693,129	0.296	$4,367,092	62.3%	52.7%	84.6%	$673,962
Pediatric Medicine	$5,026,213	$3,561,224	0.178	$5,658,565	112.6%	70.9%	62.9%	$2,097,342
Family Practice	$4,417,201	$2,709,493	0.354	$4,117,651	93.2%	61.3%	65.8%	$1,408,158
Diagnostic Radiology	$2,950,526	$1,135,531	0.275	$1,041,178	35.3%	38.5%	109.1%	-$94,353
Orthopedic Surgery	$2,748,864	$779,109	0.263	$1,324,141	48.2%	28.3%	58.8%	$545,031
Internal Medicine	$2,372,823	$1,364,951	0.216	$2,054,178	86.6%	57.5%	66.4%	$689,227
Anesthesiology	$2,186,467	$619,258	0.338	$608,643	27.8%	28.3%	101.7%	-$10,616
Psychiatry	$2,149,118	$1,145,004	0.375	$1,804,090	83.9%	53.3%	63.5%	$659,086
General Surgery	$1,901,230	$572,039	0.319	$896,698	47.2%	30.1%	63.8%	$324,659
Ophthalmology	$1,159,501	$527,938	0.348	$1,078,904	93.0%	45.5%	48.9%	$550,966
Otolaryngology	$999,189	$346,916	0.242	$526,843	52.7%	34.7%	65.8%	$179,927
Cardiology	$854,270	$307,686	0.405	$510,344	59.7%	36.0%	60.3%	$202,657
Neurology	$580,173	$248,179	0.324	$309,998	53.4%	42.8%	80.1%	$61,819
Urology	$578,459	$193,809	0.281	$309,798	53.6%	33.5%	62.6%	$115,990
Pathology	$470,364	$191,453	0.298	$158,983	33.8%	40.7%	120.4%	-$32,470
Gastroenterology	$291,220	$108,307	0.370	$154,507	53.1%	37.2%	70.1%	$46,199
Podiatry	$195,044	$78,616	0.004	$146,638	75.2%	40.3%	53.6%	$68,022
Dermatology	$189,055	$92,160	0.272	$154,543	81.7%	48.7%	59.6%	$62,383
Allergy/Immunology	$178,543	$97,808	0.218	$138,420	77.5%	54.8%	70.7%	$40,612
Osteopath Manip Therapy	$123,546	$73,746	0.323	$137,231	111.1%	59.7%	53.7%	$63,486
Physical Med And Rehab	$106,485	$39,571	0.217	$56,401	53.0%	37.2%	70.2%	$16,830
Neurosurgery	$87,213	$33,781	0.271	$42,458	48.7%	38.7%	79.6%	$8,677
Hand Surgery	$52,414	$14,263	0.140	$26,155	49.9%	27.2%	54.5%	$11,892
Pulmonary Disease	$31,848	$12,133	3.558	$15,120	47.5%	38.1%	80.2%	$2,987
Hematology/Oncology	$24,040	$10,086	0.032	$16,493	68.6%	42.0%	61.2%	$6,407
Cardiac Surgery	$13,515	$4,677	0.348	$4,203	31.1%	34.6%	111.3%	-$473
Plastic Surgery	$9,755	$2,474	0.485	$5,205	53.4%	25.4%	47.5%	$2,731
Emergency Medicine	$1,142	$618	1.515	$730	63.9%	54.1%	84.7%	$111
Nephrology	$333	$171	0.416	$274	82.2%	51.3%	62.3%	$103
Endocrinology								$0
Grand Total	**$69,792,765**	**$29,057,575**	**0.284**	**$41,586,700**	**59.6%**	**41.6%**	**69.9%**	**$12,702,030**

a/ Actual Medicaid payment is allowed amount less co-payment and other insurance payments.
Source: Office of Vermont Health Access (OVHA).

E. Health Plan Certification and Cost Control Incentives

The program would be open to all health plans operating in Vermont who are certified by BISHCA as providing the prescribed benefits and conforming to the provider payment requirements and other program rules. In addition, to encourage competition among health plans,

beneficiaries are required to pay the full increment of cost to enroll in a plan that is more costly than the lowest-cost certified voucher plan in the state.

1. Certification

The Commissioner of Banking, Insurance, Securities, and Health Care Administration (BISHCA) would certify plans for participation in the program. To be certified, health plans must offer the benefits package described above and be willing to administer the premium and cost-sharing vouchers. The insurer must also agree to reimburse providers at 110 percent of Medicare levels for services provided under these plans.

These plans must meet the same management and reserve requirements that apply in the small group and individual markets. Plans also would be required to give beneficiaries access to all providers participating in the plan's network to assure adequate access for all beneficiaries.

The state would have the option of making health plan participation either optional or mandatory. If left optional, health plans would decide whether they wish to participate. If the state cannot attract enough insurers voluntarily, the state could require participation by all health plans operating in the state's small group and/or individual markets. The mandate could be limited to only carriers with substantial numbers of enrollees in these markets (e.g., 30,000 or more lives) so that the requirement does not cause carriers with low market shares to leave the state.

Due to low levels of competition among health plans in the state (discussed below) it is unclear how many plans (if any) would opt to participate voluntarily especially given the extra burden to pay 110 percent of Medicare rates and the requirement that plans collect co-payment and cost sharing payments instead of the providers.

BISHCA would review the premiums for these plans as an extension of the current rate setting process. However, the maximum loss ratio allowed for these plans would be 85 percent rather than the 70 percent that currently applies to the small group and individual markets. This higher minimum loss ratio reflects the fact that the state would handle the enrollment process and that there would be no fees for brokers and agents. (This minimum loss ratio is consistent with the 15 percent administrative load assumption used in our actuarial analysis discussed below.)

2. Cost Control Incentives

Participants would be given a financial incentive to enroll in lower-cost health plans. The premium amount that VHAP would pay would be equal to the premium for the lowest-cost certified health plan in the area, less the beneficiary premium contribution amount. Participants could opt to enroll in a more costly certified plan if they wish, but would be required to pay the full incremental cost of electing a higher-cost health plan, even if this exceeds the 5 percent of income cap on cost-sharing.

Beneficiaries would experience this price competition as differences in premium contribution requirements for the alternative health plans available to the individual. This is intended to create

a financial incentive for beneficiaries to enroll in lower-cost health plans. However, as discussed below, there are few health plans now operating in the Vermont insurance markets. Consequently, it is unclear whether the competitive features of the program would generate significant savings.

F. Actuarial Analysis and Budget Neutrality Considerations

In this section, we estimate the effects of the voucher model on coverage and program costs. We performed an actuarial analysis based upon VHAP and SCHIP program data. We supplemented these data with the results of an actuarial analysis performed by MMC Enterprise Risk Consulting (MMCER) for the Office of Vermont Health Access (OVHA) in January and February of 2002. We also estimated the change in VHAP/SCHIP program enrollment due to changes in program premium contribution requirements and estimate whether the state would need to implement enrollment caps and waiting lists to remain within budgeted levels.

Our analysis is presented in the following sections:

- Historical costs, Trends and Beneficiary Contributions;
- Provider Reimbursement Increases and Insurer Administrative Costs;
- Impact of Increased Cost-Sharing;
- Beneficiary Premium Contributions and the Effect on Enrollment;
- The Effect of Adverse Selection on Benefit Costs;
- Five-year Cost Projections; and
- Impact on the uninsured.

1. Historical Costs, Trends, and Beneficiary Contributions

Actuarial costs under the program are estimated on a per-member per-month (PMPM) basis. Based on analyses of program data by MMCER we estimated the cost of the VHAP and SCHIP programs under current law. [11]This analysis shows that in FY 2001, the incurred claim costs for the current VHAP program were $141.32 PMPM for adults and $63.23 PMPM for children (July 2000 – June 2001). This includes an adjustment of 4 percent to convert from paid claims data to incurred claims estimates.

The costs were adjusted to calendar year 2003 based upon the following annual cost trends:

Professional Services	6.0%
Inpatient Hospital	4.7%

[11] Letters from Karen Bender of MMC Enterprise Risk Consulting, Inc (MMCER) to Mr. Paul Wallace-Brodeur, January and February 2002.

Outpatient Hospital	14.0%
Prescription Drugs	20.0%
All Other	6.0%

Based on this adjustment, the gross PMPM costs for the program in 2003 before accounting for the recent reduction in benefits would be $178.35 for adults and $78.85 for children in CY 2003 ***(Figure 9).***[12]

Figure 9
Derivation of PMPM Costs for Voucher Program Enrollees in 2003

	Adults	Children
Current Program Cost in 2003		
Claim cost in FY01	141.32	63.23
Adjust to 1/1/03	*37.03*	*15.62*
Claim cost in CY03	178.35	78.85
With Benefit Changes & Cost Sharing		
Effect of benefit changes	*(22.47)*	-
Updated claim cost in CY03	155.88	78.85
Beneficiary cost sharing	*25.38*	*5.93*
Updated gross cost in CY03	181.26	84.78
Conversion to Private Coverage		
Premium effect of reimbursement increase	*35.96*	*20.25*
Claim cost with reimbursement increase	191.84	99.37
Beneficiary cost sharing with reimbursement increase	*31.23*	*7.48*
Gross cost with reimbursement increase	223.07	106.85
Private insurer administration	*33.85*	*17.54*
Total premium (claim cost plus admin.)	225.69	116.91
Total premium plus cost sharing (i.e., gross cost plus admin)	256.92	124.39
Less: *premium effect of increased cost sharing*	*(44.50)*	*(29.03)*
Revised premium (claim cost plus admin.)	181.19	87.88
Beneficiary cost sharing (with cost sharing increase)	*47.63*	*20.45*
Revised premium plus cost sharing	228.81	108.33
Premium Voucher Restrictions		
Revised premium (claim cost plus admin.)	181.19	87.88
Less: *beneficiary premium contribution*	*(20.14)*	*(40.00)*
Revised premium net of beneficiary contribution	161.04	47.88
Selection effect	*20.60*	*3.28*
Premium with selection effect	201.79	91.16
Premium voucher amount (i.e., net of beneficiary contribution)	181.64	51.16
Co-payment Voucher Provisions		
Co-payment voucher amount	38.36	13.27
Total cost of voucher program	220.00	64.42
Net Cost Effect		
Updated claim cost in CY03	155.88	78.85
Less: *current beneficiary contribution*	*(3.64)*	*(31.25)*
Cost of current program	152.24	47.60
Net cost increase (decrease) of voucher program	$67.76	$16.82

Source: Lewin Group Estimates.

[12] This estimate reflects the elimination of Dental benefits by none of the benefits changes implemented this year.

The effect of the benefit changes enacted this year is a decrease in costs for adults of $22.47 PMPM, resulting in a PMPM cost of $155.88. These benefit changes do not apply to SCHIP children so that the PMPM cost for children under the current benefits packages is $78.85. Since this cost decrease was not included in MMCER's analysis, we have applied a scale factor to MMCER's estimates of the effects of certain program changes (specifically, the increase in provider reimbursement rates and the increase in beneficiary cost sharing). This scale factor for adults is 155.88/178.35 = 0.874, which is the ratio of the cost after reflecting the benefit changes to the cost prior to reflecting these changes.

As discussed above, the current VHAP program imposes co-payment requirements on adult beneficiaries that we estimate average about $25.38 PMPM for adults and about $5.93 PMPM for children. This includes co-payments of $7.00 for physician visits, $25 for outpatient visit, $25 per emergency room visit ($60.00 for non-emergencies), $50 per inpatient visit and 50 percent of prescription drugs up to a maximum co-payment limit of $750. The current program has no co-payment requirement for children except for the 50 percent co-payment for drugs.

Beneficiary Cost sharing was derived from claims data provided by OVHA. Using these data, we determined that beneficiary cost sharing for adults is approximately 14 percent of the gross claim cost, or 16.28 percent (.14/(1.0-.14)) of the net claim cost. For children, the cost sharing requirement – averaged across all categories of benefits – is approximately 7 percent of the gross claim cost, or 7.52 percent (.07/(1.0-.07)) of the net claim cost. Thus, the average beneficiary cost sharing amount under the current program in CY 2003 would be $25.38 PMPM for adults and $5.93 PMPM for children. This yields a gross cost (claim cost plus beneficiary cost sharing) of $181.26 PMPM for adults and $84.78 PMPM for children.

2. Provider Reimbursement Increases and Insurer Administrative Costs

Under the voucher program, provider payments would be increased to 110 percent of Medicare levels for professional and hospital services. This is an increase from 69 percent of Medicare levels for professional services and 83 percent of costs for hospital services (this is equivalent to 88 percent of Medicare levels for hospital services). Reimbursement levels also would be modified for prescription drugs and other services.

? The current VHAP experience reflects Medicaid reimbursement levels, which are:

- Professional fees 69% of Medicare RBRVS
- Inpatient Hospital 83% of costs
- Outpatient Hospital 100% of costs
- Prescription Drugs AWP – 11.9% plus rebates [FY rebates 28% of costs)

? The proposed plans will have the following reimbursement levels

- Professional fees 110% of Medicare RBRVS
- Inpatient Hospital 110% of Medicare [Medicare reimbursements represent 94% of costs]
- Outpatient Hospital 100% of costs
- Prescription Drugs AWP – 14% plus rebates (expected to be 3%)

MMCER estimated that this increase in provider reimbursements would raise the pure premium (i.e., claims costs without administration) for the VHAP program by $35.96 PMPM for adults and $20.25 PMPM for children (***Figure 9*** above). Applying the scale factor described above results in a cost increase of $35.96 for adults. These increases result in a pure premium of $191.84 PMPM for adults and $99.37 PMPM for children.

MMCER also estimated that private insurer administrative costs would be 15 percent of the total premium. This leads to a total monthly premium of $225.69 ($191.84/0.85) for adults and $116.91 ($99.37/0.85) for children. Adding in beneficiary cost sharing, the gross cost including insurer administrative expenses would be $256.92 for adults and $124.39 for children.

3. Impact of Increased Cost-Sharing

Under the voucher program, flat-dollar co-payments would be replaced by a $500 annual deductible and a 20% cost-sharing requirement for the next $5,000 of claims, for an annual out-of-pocket maximum of $1,500. The cost-sharing provisions for prescription drugs (no deductible, 50 percent cost sharing requirement for the first $1,500 of claims, for an annual out-of-pocket maximum of $750) would remain unchanged.

MMCER estimated that the change in cost-sharing requirements would reduce PMPM costs by $44.52 for adults and $29.03 for children (reflects scale factor described above). The resulting monthly premium for the voucher benefits package is $181.19 for adults and $87.88 for children. Adding in beneficiary cost sharing, the gross cost would be $228.81 for adults and $108.33 for children (***Figure 8*** above).

4. Beneficiary Premium Contributions and the Effect on Enrollment

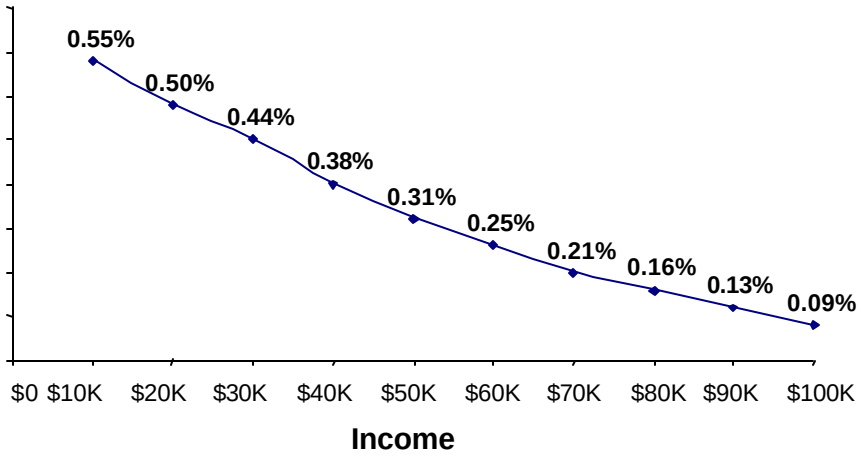
Beneficiaries would be given a voucher equal to the monthly premium less the share of the premium that they would be required to pay. The beneficiary's share of the premium would vary by income (expressed as a percentage of the federal poverty level) as it does under the current program. However, the beneficiaries premiums would be up to about $46.00 per-month higher than under the current program. The average beneficiary contribution would be $20.14 PMPM for adults and $40.00 PMPM for children.

The increase in premiums paid by beneficiaries would result in a decrease in enrollment in the voucher program. Based on an analysis of the price elasticity of health insurance, The Lewin Group estimates that for every 1 percent increase in the premium (i.e., in the beneficiary contribution) for a health insurance plan, enrollment drops by anywhere from 0.44 percent to 0.6 percent, depending upon the beneficiary's income level (***Figure 10***).[13] Also, based upon historical data on enrollment in public programs with premium requirements, we estimate that requiring a premium reduces enrollment by about 37 percent and that each additional 1 percent

[13] Sheils, J., Hogan, P., and Manolov, N., "Exploring the Determinants of Employer Health Insurance Coverage," (Report to the AFL-CIO), 1998.

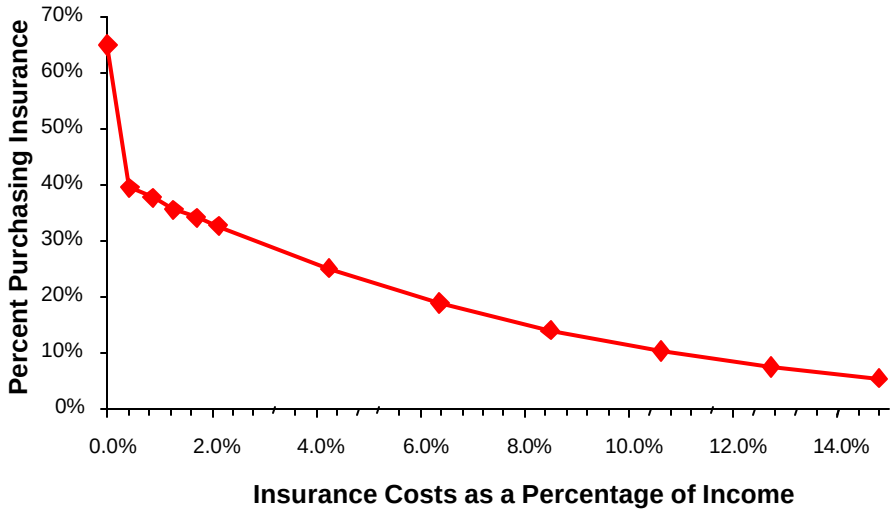
of income increase in the premium causes enrollment to drop by between 1.25 and 5.0 percentage points (***Figure 11***).[14]

Figure 10
Percentage Increase in Coverage Resulting from a One-Percent Reduction in Premiums by Income Level (in percentages) a/



a/ Indicates a price elasticity ranging between –0.55 to –0.09 by income.
Source: Lewin Group estimates.

Figure 11
Estimated Percentage of Persons Who Will Take Subsidized Coverage by Premium Cost as a Percentage of Family Income



Source: Lewin Group Analysis of enrollment data for programs with premium contribution requirements.

[14] John Sheils and Randall Haught, "Covering America: Cost and Coverage Analysis of Ten Proposals to Expand Health Insurance Coverage", Appendix A, (report to the Robert Wood Johnson Foundation), August, 2002, The Lewin Group.

Based upon these assumptions, we estimate a 13 percent drop in enrollment for adults (compared to the current program's enrollment) due to the increase in beneficiary premium contributions (***Figure 12***). For children, the monthly premium contribution would increase from an average of about $31 per child under the current program to about $40 under the voucher.[15] We estimate that this would result in a reduction in enrollment for affected children of about 3 percent. (Note that the average annual income for each percent of FPL category is based on the FPL for a family of three in CY 2003).

Figure 12
Estimated Change in Enrollment Resulting from the Premium Increase Under the Voucher Model in 2003

		Current Program			Voucher Program		
Percent of FPL	**Annual Income**	**Monthly Premium**	**Percent of Income**	**2003 Enrollment**	**Monthly Premium**	**Percent of Income**	**2003 Enrollment**
Adults							
0-25	$1,925	$0.00	0.0	4,225	$0.00	0.0	4,225
25-50	$5,783	$0.00	0.0	1,286	$0.00	0.0	1,286
50-75	$9,638	$1.67	0.0	2,756	$8.33	0.1	2,177
75-100	$13,493	$2.50	0.0	2,756	$16.67	0.1	2,132
100-125	$17,348	$5.00	0.1	3,674	$33.33	0.25	2,723
125-150	$21,203	$6.67	0.1	3,674	$33.33	0.2	3,385
150-175	$25,058	$8.33	0.1	1,920	$45.83	0.2	1,720
175-185	$27,756	$8.33	0.1	768	$54.17	0.2	570
Total Adults		**$3.64**		**21,059**	**$20.14**		**18,218**
Children							
225-300	$25,298 a/	$31.25	0.2	3,227	$40.00	1.9	3,135

a/ Adjusted to reflect 1.6 children per family
Source: Lewin Group analysis of VHAP and SCHIP program data.

5. The Effect of Adverse Selection on Benefit Costs

The beneficiaries who remain with the program are expected to be those most likely to need health services. In other words, those who terminate coverage will be healthier, on average, than those who choose to continue.[16] We estimate that this adverse selection would increase the premium by $20.60 PMPM for adults and $3.28 PMPM costs for children.

This would result in a total monthly premium (before subtracting the beneficiary's share) of $201.79 for adults and $91.16 for children. After subtracting the beneficiary's contribution (an average of $20.14 PMPM for adults and $40.00 PMPM for children), the average premium voucher amount will be $181.65 for adults and $51.16 for children (***Figure 9*** above).

[15] Under the current program, the monthly beneficiary contribution for children is $50 per family, or $31.25 per child based on an average of 1.6 children per family.
[16] We are assumed that half of the terminating beneficiaries would be among the least costly beneficiary group (those with gross claims of less than $100 per year), with the other half of terminating beneficiaries evenly distributed among those beneficiaries with claims over $100.

6. Co-payment Voucher

Finally, beneficiaries would be given a voucher to cover a portion of the cost-sharing requirements under the benefits package. The cost-sharing voucher would be enough to limit cost-sharing payments to a specified level that varies with income. The PMPM cost of this voucher to the state is expected to average $38.36 for adults and $13.27 for children. This brings the total PMPM cost of the voucher program to $220.00 for adults and $64.42 for children (***Figure 9*** above).

Taken together, the cost changes estimated above represent an increase in program spending of $67.76 PMPM for adults and $16.82 PMPM for children.

7. Five year Cost Projections

Medicaid 1115 waivers are typically approved for a five-year period. However, the Center for Medicare and Medicaid Services (CMS) requires that 1115 waiver proposals be budget neutral. This means that total federal expenditures for the waiver population over this five-year period can be no greater than what it would have been for this population in the absence of the waiver. Therefore it is necessary to provide projections of spending for the waiver population over a five-year period with and without the waiver. We assume that the waiver period would be calendar years 2003 through 2007.

As discussed above, total benefit payments under the current VHAP and SCHIP programs would be about $40.3 million in 2003. Under the waiver, costs would increase by about $10.2 million despite the reduction in the number of enrollees (i.e., 2,933) due to the premium increases. This would require implementing enrollment caps sufficient to hold program costs to what they would have been in the absence of the waiver. This would require an additional reduction in enrollment of 4,313 persons, thus bringing the total reduction in enrollment of 7,246 persons. This enrollment reduction is equal to about 29.8 percent of total VHAP and SCHIP enrollment without the waiver in that year (24,286 people).

Figure 13 presents estimated enrollment and costs over the 2003 through 2007 period. In developing these estimates we assumed that enrollment would increase with the rate of growth in the population over this period (assumed to be about 1.0 percent per year). We assumed that costs would grow at the same rates assumed by MMCER over the 2001 through 2003 period (about 12.4 percent per year).

Figure 13 also shows costs and enrollment under the waiver assuming no enrollment caps. Spending and enrollment under the voucher model with the enrollment caps are shown in ***Figure 14.***

Figure 13
Five-year Projection of Costs under Current VHAP Program and VHAP Voucher Program (without enrollment cap)

	2003			2004			2005			2006			2007		
	Adults	Children	Combined	Adults	Children	Combined	Adults	Children	Combined	Adults	Children	Combined	Adults	Children	Combined
Current Program															
Number of enrollees	21,059	3,227	24,286	21,270	3,259	24,529	21,482	3,292	24,774	21,697	3,325	25,022	21,914	3,358	25,272
PMPM state cost a/	152.24	47.60	--	167.16	52.26	--	183.54	57.39	--	201.53	63.01	--	221.28	69.19	--
Total annual state cost	38,472,266	1,843,262	40,315,528	42,664,973	2,044,141	44,709,115	47,314,602	2,266,912	49,581,514	52,470,948	2,513,960	54,964,907	58,189,231	2,787,931	60,977,162
Voucher Program															
Number of enrollees	18,218	3,135	21,353	18,400	3,166	21,567	18,584	3,198	21,782	18,770	3,230	22,000	18,958	3,262	22,220
PMPM state cost	220.00	64.42	--	241.56	70.73	--	265.23	77.67	--	291.23	85.28	--	319.77	93.63	--
Total annual state cost	48,095,520	2,423,480	50,519,000	53,336,970	2,687,591	56,024,561	59,149,633	2,980,485	62,130,118	65,595,760	3,305,298	69,980,980	72,744,386	3,665,510	76,409,895
Net Cost Effect															
Total annual state cost	9,623,254	580,218	10,203,472	10,671,996	643,450	11,315,446	11,835,030	715,573	12,548,604	13,124,812	791,339	13,916,151	14,555,154	877,579	15,432,733

a/ State cost net of beneficiary co-payments and premium contributions.
Source: Lewin Group estimates

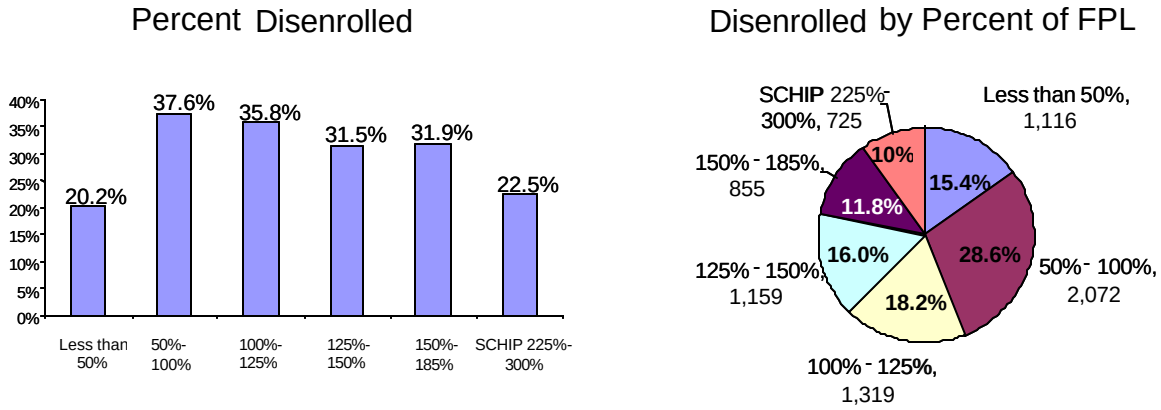
Figure 14
Five-year Projection of Costs under Current VHAP Program and VHAP Voucher Program (with enrollment cap)

	2003			2004			2005			2006			2007		
	Adults	Children	Combined	Adults	Children	Combined	Adults	Children	Combined	Adults	Children	Combined	Adults	Children	Combined
Current Program															
Number of enrollees	21,059	3,227	24,286	21,270	3,259	24,529	21,482	3,292	24,774	21,697	3,325	25,022	21,914	3,358	25,272
PMPM state cost	152.24	47.60	--	167.16	52.26	--	183.54	57.39	--	201.53	63.01	--	221.28	69.19	--
Total annual state cost	38,472,000	1,843,000	40,315,000	42,665,000	2,044,000	44,709,000	47,315,000	2,267,000	49,582,000	52,471,000	2,514,000	54,985,000	58,189,000	2,788,000	60,977,000
Voucher Program															
Number of enrollees	14,538	2,502	17,040	14,683	2,527	17,210	14,830	2,552	17,383	14,979	2,578	17,556	15,128	2,604	17,732
PMPM state cost	220.00	64.42	--	241.56	70.73	--	265.23	77.67	--	291.23	85.28	--	319.77	93.63	-
Total annual state cost	38,381,000	1,934,000	40,315,000	42,564,000	2,145,000	44,709,000	47,203,000	2,379,000	49,582,000	52,347,000	2,638, 000	54,985,000	58,052,000	2,925,000	60,977,000
Net Cost Effect															
Total annual state cost	-91,000	91,000	0	-101,000	101,000	0	-112,000	112,000	0	-124,000	124,000	0	-137,000	137,000	0

8. Impact on Insurance Coverage

Few of those who are disenrolled from the program are expected to obtain coverage. The distribution of the 7,246 persons who would be disenrolled is shown by income in ***Figure 15.*** About 44 percent of those who would disenroll have incomes below the FPL. The disenrolled would include about 6,521 adults and about 725 children.

Figure 15
Reduction in Enrollment by Income as a Percent of FPL



Total Enrollment Reduction = 7,246

Source: Lewin Group estimates.

This would increase the number of uninsured in the state by about 14.2 percent ***Figure 16***. The number of uninsured in Vermont would increase from the current estimate of 51,400 persons to about 58,700 persons.[17] The number of uninsured children in the state would increase by about 11 percent from its current level of 6,400 children to about 7,100 children. The number of uninsured adults would increase from about 45,000 people to about 51,500.

Figure 16
Impact of the VHAP/SCHIP Waiver on the Number of Uninsured in the State

	Current Law (in thousands)	With Waiver (in thousands)	Percent Change
Children	6.4	7.1	10.9%
Adults	45.0	51.5	14.4%
Total	51.4	58.7	14.2%

Source: Lewin Group Estimates based upon data from the Division of Health Care Administration, BISHCA 2000 VT Family Health Insurance Survey.

This reduction is coverage is likely to result in an increase in uncompensated care expenses for providers. This would largely offset the net increase in provider reimbursement under the waiver. Moreover, there would be a decline in the use of primary care that could lead to long-run increases in uncompensated care.

[17] Vermont Division of Health Care Administration BISHCA 200 VT Family Health Insurance Survey.

G. Delivery System

The degree of competition among health plans in the state has important ramification for the waiver proposal. As discussed above, one of the reasons for moving the VHAP and SCHIP population to private plans under the waiver is to help control costs by allowing health plans to compete for enrollment. The amounts of the vouchers under the waiver would be equal to the premium for the lowest cost participating plan in the state (less the beneficiary contribution amount), thus requiring beneficiaries to pay the full increment of cost for enrolling in a more costly plan. This is intended to spark price competition among insurers for enrollment.

In this section, we assess the degree of competition among insurers in Vermont. We also evaluate the degree of competition among providers, which can be an important determinant of the insurers ability to compete on price through formation of provider networks.

1. Insurer Competition in Vermont

An important issue in Vermont is the perceived lack of competition among insurers. Vermont has fewer insurers serving the individual and group markets than most other states. A nationwide study of health insurance markets found that in 1997, there were 15 insurers serving Vermont's group market (including small and large groups) and that 90 percent of the market were covered by just the three largest carriers in the state ***(Figure 17).***

By comparison, larger states typically had more insurers and a smaller concentration of enrollment in the largest plans. For example, Massachusetts had 55 insurers in the group market with only about 55 percent of the market concentrated among the largest plans. The study found that Vermont had fewer carriers participating in both the group and the individual insurance markets than any of the other New England states.

The number of insurers serving the group and individual markets has declined in Vermont since 1997, reflecting a general reduction in the number of health plans in these markets nationally. The three largest plans in the state are now BlueCross BlueShield (BCBS) of Vermont, MVP health plan and CIGNA.

MVP is an HMO and BCBS offers an HMO product. When the VHAP program was created, much of the enrollee population was enrolled in HMOs. However, the VHAP population was shifted to a Primary Care Case Management (PCCM) model after the Kaiser health plan left the state. Overall, about 18.3 percent of people in Vermont are enrolled in an HMO. This compares with an average of 28.1 percent nationwide and 32.1 percent in the New England states ***(Figure 18)***.[18]

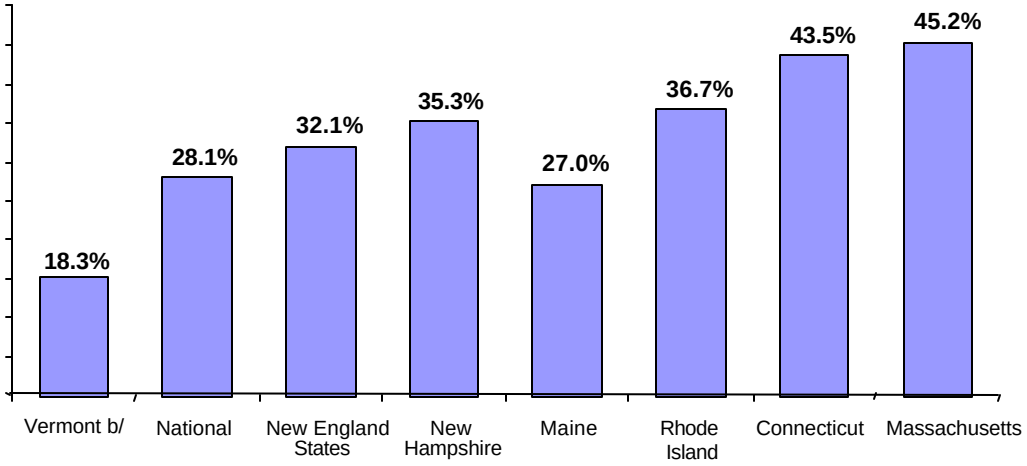
[18] The Interstudy Competitive Edge, Part II: HMO Industry Report", Interstudy a Division of Decision Resources inc.

Figure 17
Summary Comparison of Medicaid Payments for Selected Non-Hospital Services in 1997 [a/]

Carrier	Lives	Percent of Total
Individual (Non-Group) Market		
BlueCross BlueShield of Vermont	10,222	64%
Mutual of Omaha Insurance Company	4,609	29%
Nationwide Life Insurance Company	591	4%
Fortis Insurance Company	61	0%
MVP Health Plan, Inc.	216	1%
Other Plans	308	2%
Medical - Individual Market Total	**16,007**	**100%**
Small Group Market		
MVP Health Plan, Inc.	21,163	46%
Allianz Life Insurance Company of North America	11,657	25%
Vermont Health Plan	7,729	17%
John Alden Life Insurance Company	3,834	8%
BlueCross BlueShield of Vermont	1,193	3%
Other Plans	636	1%
Small Group Total	**46,212**	**100%**
Association Health Plans		
BlueCross BlueShield of Vermont	66,621	90%
Vermont Health Plan	4,093	6%
Connecticut General Lifer Insurance Company	2,247	3%
John Hancock Mutual Life Insurance Company	148	0%
New York Life Insurance Company	182	0%
Other Plans	840	1%
Association/Trust Total	**74,131**	**100%**
Large Group Plans		
MVP Health Plan, Inc.	36,988	32%
BlueCross BlueShield of Vermont	25,265	22%
Vermont Health Plan	15,718	13%
Connecticut General Lifer Insurance Company	19,011	16%
United Healthcare Insurance Company	3,258	3%
Other Plans	17,020	15%
Large Group Total	**117,260**	**100%**

Source: 2000 Annual Statement Supplement Report, Department of Banking, Insurance, Securities, and Health Care Administration.

Figure 18
HMO Enrollment as a Percent of the State Population [a/]



a/ Includes HMO enrollment in Medicare, Medicaid and private health plans.
b/ HMO enrollment in Vermont includes 58,367 people in the Mohawk Valley Health Plan (MVP), 27,540 people in the Vermont Health Plan and 25,445 people in BCBS VHP.
Source: Interstudy, a division of Decision Resources, Inc., "The Interstudy Competitive Edge: Part II: HMO Industry Report, July 1, 2000; and data on HMO enrollment provided by BISCHA.

Some of the reasons for the low level of lack of competition among insurers include:

- Health plans have consolidated;
- Entering a highly regulated market for a relatively small number of covered lives is not attractive to most insurers.
- Those companies who were not skilled at actually managing care left the state when they were no longer able to profit from risk selection (i.e. marketing coverage to only lower cost groups).
- Lack of competition among providers makes it difficult to form effective provider networks.
- Talk of a single-payer system makes insurers uneasy about investing in Vermont.

Another issue with this waiver is insurer willingness to participate in the program. To be eligible to participate, insurers must develop benefits packages that conform to the requirements under the program, including the administration of the cost sharing voucher. The insurer is also responsible for collecting the beneficiaries' share of the premium. In addition, all of the providers in their networks must also accept 110 percent of Medicare payment levels for their services (Under the program, beneficiaries must have access to all providers in the insurer's network). Insurers may not want to make the changes needed to qualify for a relatively small number of people (about 17,000 people).

2. Hospital Competition in Vermont

One of the most important reasons for low competition among insurers is that there is little competition among health care providers in the state. For example, of the 14 hospitals in the state, 12 are the only hospital within 30 miles. This makes each hospital a monopoly in their market area, which contributes to the difficulty carriers have in negotiating favorable terms with providers. Also, over half of all hospital care for Vermonter's is provided in just two medical centers; Fletcher Allen Health Care in Burlington (accounts for about 52 percent of hospital net revenues for Vermont Hospitals) and Dartmouth-Hitchcock Medical Center in New Hampshire.

The lack of competition among hospitals is an important determinant of the degree of competition that is possible across health plans. This is because insurers rely largely upon negotiated volume discounts with providers to make their premiums more price competitive. Thus, the lack of competition among providers in Vermont is a limiting factor in the amount of price competition that could occur among health plans under the waiver.

To evaluate the competitive environment for hospital services in Vermont, we compare the level of competition among Vermont hospitals to that of hospitals in other New England area states (Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, and Rhode Island). We constructed an "index of competition" by partitioning hospitals into the following categories:

- **Low competition** – 0 to 5 hospitals located within a 10 (or 30) mile radius;
- **Medium competition** – 6 to 10 hospitals located within a 10 (or 30) mile radius;
- **High competition** – 11 or more hospitals located within a 10 (or 30) mile radius.

In Vermont, Maine and New Hampshire all hospitals have "low" levels of competition within a 10-mile radius. If the area is expanded to a 30-mile radius, 12 out of 14 hospitals (86 percent) of Vermont hospitals have "low" levels of competition. Results from this analysis indicate that Vermont hospitals experience a lower level of competition than other New England hospitals. (***Figure 19***).

3. Competition Among Physicians

On a per-capita basis, the supply of physicians in Vermont is higher than in most other states. Ordinarily, this would suggest that there is significant potential for competition among physicians in Vermont markets. There are several physician networks in Vermont, the largest of which is sponsored by BCBS of Vermont. Health plans have been able to negotiate some discounts with physicians through networks. However, insurers report that there is relatively little price competition among physicians in the state.

Figure 19

Level of Competition Among Hospitals Within a 30-Mile Radius

	Index of Competition			
State	**Low**	**Medium**	**High**	**Total**
Connecticut	3	5	21	29
Maine	30	4		34
Massachusetts	9	7	47	63
New Jersey	4	6	59	69
New York	47	44	95	186
New Hampshire	9	12	4	25
Rhode Island	1	2	7	10
Vermont	12	2		14
Total	**115**	**82**	**233**	**430**

Source: Lewin Group analysis using the ESRI Data & Maps CD (July 1999).

One of the primary reasons for this is that Vermont is largely rural. Many physicians are located in areas where they are the only provider in the area, which limits the bargaining leverage that health plans have in negotiating volume discounts. Also, while Vermont has a high number of physicians on a per-capita basis, these providers are mal-distributed within the state. This is true for both primary care physicians and specialists. In fact, as discussed below, a number of areas in Vermont are designated as "health professional shortage areas."

As a consequence, health plans have little bargaining leverage with providers. This is particularly true of some physician specialists. This is because the state population is barely large enough to support more than one or two physicians in a given sub-specialty throughout the state. This results in provider shortages in the areas where these providers are not located. Moreover, it leaves the health plans with little leverage in negotiating reimbursement rates the specialists that account for some of the most expensive types of medical care.

There are other barriers to forming networks in the state. First, insurers do not consider physician payment rates to be particularly high in Vermont, which limits the amount of savings that they could expect to realize through network formation. Second, a number of the hospitals in the state have established physician practices, which, due to the lack of competition among hospitals, reduces the health plan's bargaining leverage with these physicians.

H. Quality and Access

Under the current VHAP waiver program, Vermont has developed quality assurance measures and has contracted with two quality assurance contractors. The same quality measures would be applied for this waiver. However, depending on the number of plans that are certified and those that beneficiaries enroll in, the quality contract may expand or contract.

Access to providers is not likely to be a problem for people covered under the waiver. Even at the below-market reimbursement rates paid under the current Medicaid program, most providers accept VHAP and SCHIP patients.[19] However, access may become a significant problem for current VHAP/SCHIP beneficiaries who lose coverage due to the waiver. This includes people who decide not to enroll due to the higher premium requirement under the waiver, and persons who are excluded from coverage due to the enrollment cap. This reduction in coverage (7,246 people) would increase provider uncompensated care expenses, which would largely offset the gains in reimbursement for providers under the waiver.

The increased co-payments under the waiver could create some access problems for persons who remain covered under the program. Increased co-payments could cause some participants to skimp on needed care. It could also reduce the use of primary and preventive care, which could actually serve to increase costs. Therefore, the state would need to monitor these access issues as the program is implemented.

I. Medicaid Provisions to be Waived

Medicaid 1115 Waivers must meet 2 basic criteria:[20]

1. There must be an "experimental pilot or demonstration project"

2. The project must be "in the judgment of the Secretary likely to assist in promoting the objectives of the program

The following waivers of Title XIX and Title XXI would be required for the Vermont Waiver:

- **Statewideness 1902(a)(1).** This would allow Vermont to phase in the implementation of the voucher program either to specific eligibility groups or in specific areas of the state.

- **Amount, Duration and Scope 1902(a)(10)(B).** This would allow different benefit packages to different populations in the demonstration. This may be required because although there would be a minimum set benefit package, the voucher system that allows individuals to choose plans may result in varying benefits for individuals across plans.

- **Freedom of Choice 1902(a)(23).** This enables Vermont to restrict the chose of providers. Under the proposal, the state would set up a system to certify eligible plans to participate in the program. The state may also chose to contract with only select plans that are eligible.

- **Cost Sharing Requirements 2103(e).** This waiver would enable Vermont to exceed statutory cost sharing requirements. Under current law, cost sharing is capped at 2.5 percent FPL for families with incomes between 100 and 150 percent FPL and 5 percent for families

[19] Payments to providers under the program would still be about 10 percent less than private payer levels, which may cause some to avoid serving the voucher population.

[20] Mann, C. "The New Medicaid and CHIP Waiver Initiatives". *Kaiser Commission on Medicaid and the Uninsured*. February 2002.

with incomes exceeding 150 percent FPL. Vermont has requested cost sharing for families not to exceed 7.5 percent of family income.

Vermont would need to engage in discussions with CMS to determine other specific waivers that would be required. For example, a waiver may be required to enable the state to issue a voucher for payment of services.