State of Vermont

Expansion of Health Insurance Coverage to Uninsured Vermonters

Final Report

HRSA State Planning Grant
Report to the Secretary

March 15, 2002

The Vermont Agency of Human Services

with assistance from:
The Lewin Group, Inc. and
Action Research, Inc.

Supported by a grant from the Health Resources and Services Administration,
U.S. Department of Health and Human Services

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EXECUTIVE SUMMARY

Since 1992, the State of Vermont has devoted significant resources to developing and implementing creative strategies for making health care coverage available to lower income uninsured residents. The purpose of this report is to describe the activities conducted to research the characteristics of uninsured Vermonters and the current state of the insurance, employer, and health care provider marketplaces in order to identify methods to extend coverage. Additionally, this report contains the findings of the research as well as a summary of the various options developed under the grant from the Health Resources and Services Administration (HRSA).

The Vermont Agency of Human Services (AHS) worked with The Lewin Group and Action Research to lead a broad coalition of public and private organizations in undertaking this work. A Steering Committee consisting of representatives from the various stakeholder groups met regularly and participated in planning and advising on the various research activities. During this period, a Family Health Insurance Survey was fielded by the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) which provided current information on the state's population demographics, including their insurance status.

> ...about 39 percent of the uninsured in Vermont (about 20,000 people) are actually eligible for Medicaid, VHAP or Dr. Dynasaur, but are not enrolled.

Qualitative and quantitative research were conducted to develop an in-depth understanding of the characteristics of the uninsured, as well as the basis for their uninsurance and their likely responses to various options and coverage strategies. The research process was iterative in that the findings from each activity informed the next. An early research finding was that other than adopting a single-payer model, there was no single option or program which could expand coverage to include all groups of the uninsured, and that multiple options needed exploration.

Focus groups and in-depth interviews were held with employers to identify and define the criteria they use to select insurance for their employees and determine their likely participation in coverage expansions. Focus groups were held with the uninsured to understand the factors that led to their being uninsured and to determine their willingness to pay for different health insurance benefit plans. Two workgroups composed of insurers and health care providers were held in which each group's perceptions of public and private health care coverage in the state were explored and coverage options were identified. Simulations were developed to model the cost and impact of each of the various options on each stakeholder group. Focus groups were then held with employers and uninsured Vermonters to market test the options. A tentative set of options was selected by the Steering Committee and modeled.

In a parallel effort, a Bipartisan Commission on Health Care Availability and Affordability appointed by the Governor in the winter of 2001 examined options for expanding coverage to uninsured Vermonters. Several Steering Committee members regularly attended these meetings. Additionally the HRSA project staff shared results and provided analytic support to this group.

Characteristics of the Uninsured

During the course of this analysis, the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) conducted a survey of households to obtain information on health insurance coverage in the state. These data indicate that in 2000, there were 51,390 people without health insurance in the state (***Figure ES - 1***). This is equal to 8.4 percent of the state's population. About 69 percent of the uninsured indicated that they had been uninsured for over a year.

Figure ES - 1
Comparative Distribution Across Age Groups
Uninsured Vs. All Vermont Residents, 2000

Age Group	Total Population	Uninsured Population	Percentage of Age Group Uninsured
0-17	147,525	6,191	4.2%
18-29	90,768	18,194	20.0%
30-44	142,272	14,732	10.4%
45-64	150,752	10,816	7.2%
65+	77,512	1,457	1.9%
Statewide	**608,829**	**51,390**	**8.4%**

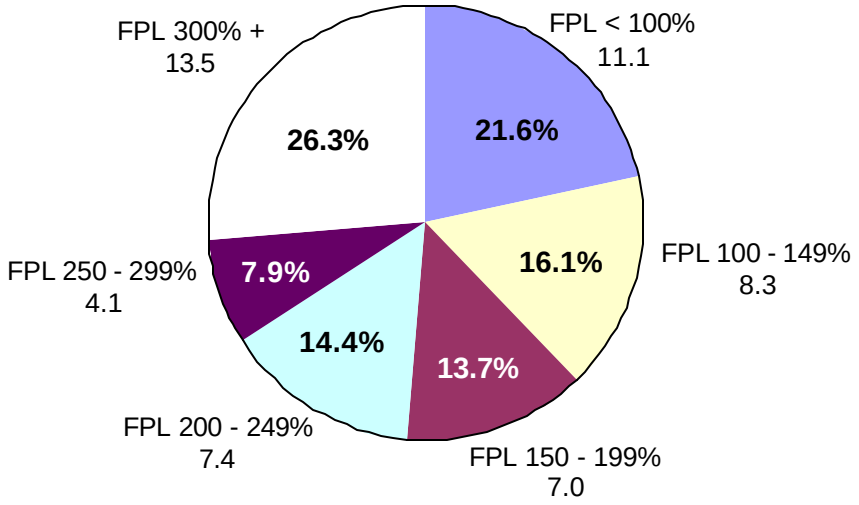
Source: Vermont Division of Health Care Administration, BISHCA 2000 VT Family Health Insurance Survey.

These data indicate that young adults have the highest concentration of uninsured people. About 20 percent of people age 18 to 29 were uninsured compared to 10.4 percent of adults age 30 to 44 and 7.2 percent for people age 45 - 64. Only about 4.2 percent of children are uninsured, which reflects recent expansions in eligibility for the Dr. Dynasaur program.

The uninsured are found at all income levels (***Figure ES-2***). About 51.4 percent of the uninsured are living below 200 percent of the Federal Poverty Level (FPL). Another 22.3 percent have incomes between 200 and 299 percent of the FPL while 26.3 percent have incomes in excess of 300 percent of the FPL. Based on these data, Lewin estimates that about 39 percent of the uninsured in Vermont (about 20,000 people) are actually eligible for Medicaid, VHAP, or Dr. Dynasaur but are not enrolled.

Two focus groups were conducted with uninsured Vermonters to better understand the reasons why some individuals and families go without insurance. 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 are uneasy about being uninsured.

Figure ES - 2
Distribution of the Vermont Uninsured by Federal Poverty Level, 2000
(in thousands)



Total Estimated Uninsured = 51.4

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

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 are 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.

Personal health spending in Vermont was equal to about 12.7 percent of the state's Gross Domestic Product (GDP). This compares with 11.6 percent nationally and 12.2 percent in the New England states. Thus, despite the fact that per-capita spending in Vermont is less than in other states, health spending in Vermont comprises a larger share of state income (as measured by the state's GDP).

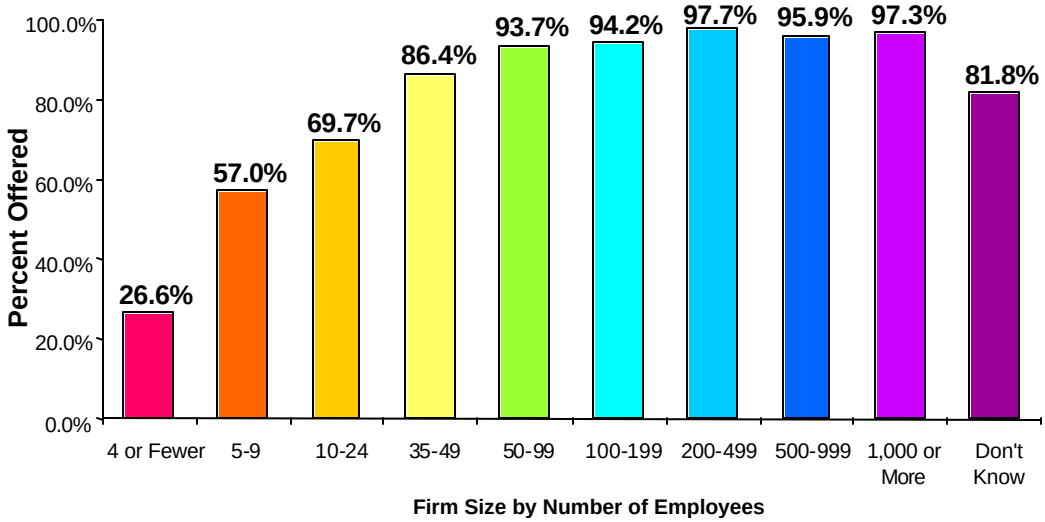
Access to Employer-sponsored Coverage

According to the 2000 Vermont Family Health Insurance Survey, more than three-quarters of the uninsured population over the age of 18 are employed. Of these uninsured adults, about 66.5 percent were working full-time, 10.5 percent were working part-time, and 23.1 percent were not working for pay (i.e., homemakers, students, retirees and unemployed). These data suggest that programs to expand employer-sponsored coverage could have a significant impact on the state's uninsured.

People who work for employers that do not provide coverage tend to be in smaller firms. In 2000, the proportion of employees offered health insurance ranged from 26.6 percent in firms with fewer than 5 employees, to over 90 percent in firms with over 50 employees (***Figure ES - 3***). It should be noted however, that some of the workers in these firms do not take coverage

when offered, even if they have no other insurance, largely due to the cost of the coverage to the worker under these plans. Overall, about one-third of all uninsured working adults are employed in a firm with fewer than 5 workers.

Figure ES - 3
Percentage of Workers Offered Health Insurance by Self-Reported Firm Size, Vermont Workers Age 18+, 2000



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

Sixteen focus group sessions and 11 structured interviews were conducted with employers to gain their perspectives on health insurance. 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 time required to research and administer plans.

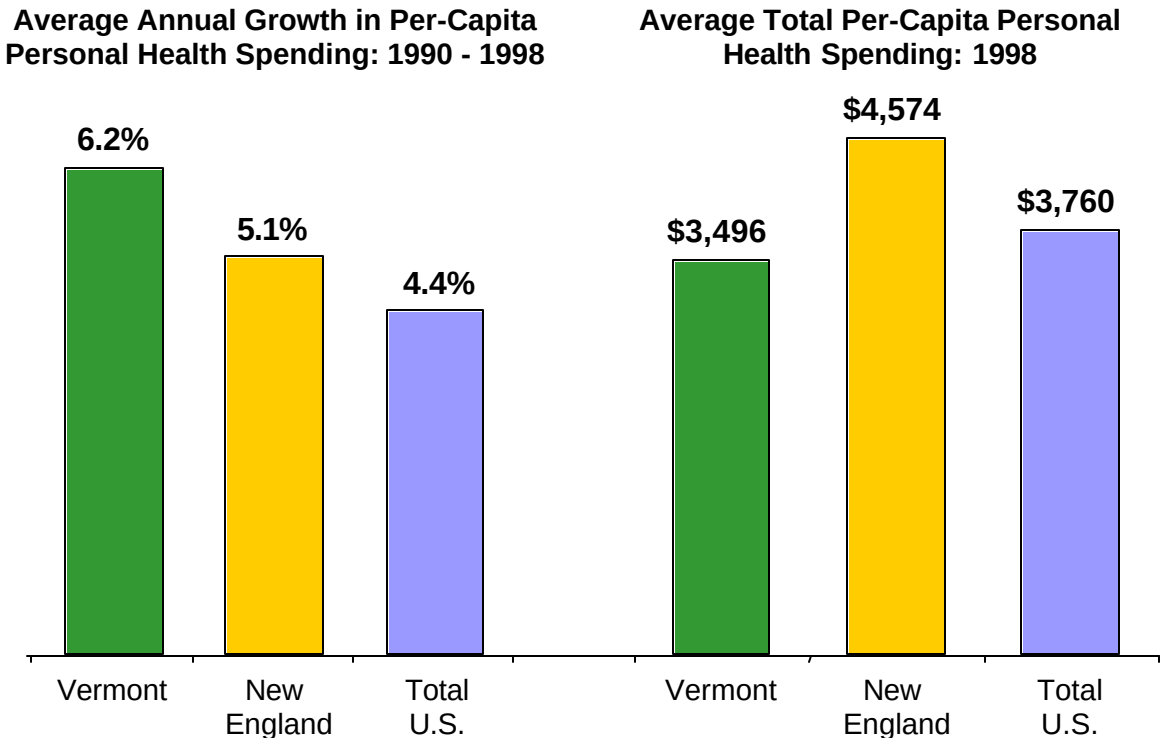
However, nearly all participating employers expressed significant frustration with the state of health insurance today. Participants feel that health insurance costs are completely "out of their control," and believe it is impossible to predict, plan or budget for annual health care expenditures. While most insuring employers plan to continue to offer coverage, many can foresee a time when they will need to significantly change the structure of the benefits they offer, whether by increasing the employee premium contribution, raising co-payments and deductibles, or reducing the benefits covered.

Health Spending in Vermont

Per-capita health spending in Vermont is below the national average. Data from the Centers for Medicare and Medicaid Services (CMS) indicates that average total health spending per person in Vermont was $3,496 in 1998, compared with a national average of $3,760 (***Figure ES - 4***). Moreover, health spending in Vermont is generally below other states in New England. For

example per-capita health spending in the New England states was $4,574, which is about 30 percent higher than in Vermont (i.e., $3,496).

Figure ES - 4
Per-Capita Personal Health Spending in Selected Geographical Regions: 1990 - 1998



Source: Lewin Group analysis of the Centers for Medicare and Medicaid Services (CMS) State Health Expenditures data.

However, while health care costs in Vermont are low compared to other states, the state has experienced a higher rate of growth in health spending than other parts of the country. For example, per-capita spending in Vermont grew by an average of 6.2 percent per year, compared with a national average of only 5.1 percent, and an average of 4.4 percent across the New England states.

Based upon an evaluation of the available data for 1992 through 1999, the higher rate of growth in spending in Vermont appears to be attributed to the following:

? **Hospital Outpatient Utilization -** Utilization of hospital outpatient services increased by 8.9 percent per year compared to a national average of 4.5 percent.

? **Physician Expenditures -** Per-capita spending for physicians grew by 4.4 percent per year over this period compared with a national average of 2.9 percent.

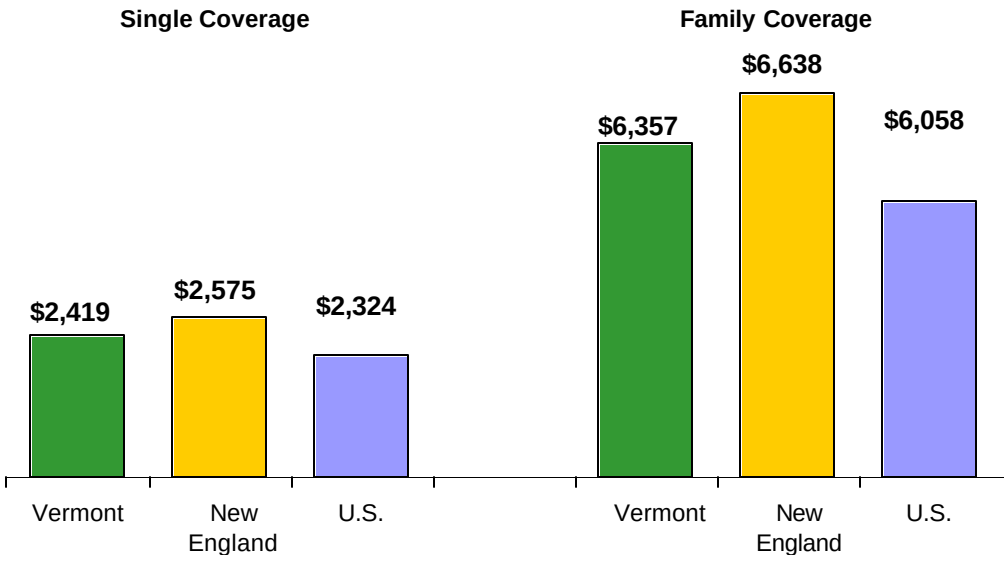
? **Reduction in the Number of Uninsured -** The percentage of Vermonters without insurance fell from 10.8 percent in 1993 to 8.4 percent in 2000, largely due to Medicaid/VHAP/Dr.

Dynasaur program expansions over this period. We would expect this to be associated with some increase in health spending.

? **Demographics -** Because Vermont includes a proportionally higher number of the baby-boom population, it has experienced a proportionally higher increase in spending as this population group ages. This effect on spending is expected to continue as the baby-boom population ages.

About 39 percent of health spending in Vermont is covered under private insurance, of which most is employer-sponsored coverage. The cost of employer-sponsored health benefits is lower than in other New England states. For example, data from the Agency for Healthcare Research and Quality (AHRQ) indicates that the average cost of employer coverage in Vermont (employee and employer share) in 1999 was $2,419 for single coverage and $6,357 for family coverage (***Figure ES - 5***). This is above the national average of $2,324 for single coverage and $6,058 for family coverage. However, Vermont spending for employer policies is less than the average for the New England states, of $2,575 for single coverage and $6,638 for family coverage.

Figure ES - 5
Average Employer-Based Health Insurance Premium Costs Per Worker in 1999



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

Competitive Environment

The state of 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. 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 insurers Lewin interviewed during this project offered a number of opinions on why there are relatively fewer insurers operating in Vermont. However, the state's community rating and other regulatory policies were cited as only one of the reasons for this. They noted that there has been a general decline in the number of carriers competing in these markets nationwide, which is related to the large losses insurers have experienced in recent years. The state's small size also limits carrier interest in moving into the state.

However, one of the most important reasons suggested by insurers interviewed is that there is relatively 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 the providers. This is crucial because insurers rely largely upon negotiated volume discounts with providers to make their premiums more price competitive. Thus, in today's insurance markets, competition among insurers is largely dependent upon the degree of competition among providers.

Provider Capacity

One of the most important issues in this analysis is determining whether providers in Vermont would have the capacity to meet the increase in demand for health services that would be expected once universal coverage is achieved. In 1980, the Graduate Medical Education National Advisory (GMENAC) established standards of physician need for the population. Based upon these standards, Vermont's supply of physicians is probably adequate to marginal, although shortages do exist in parts of the state.

Vermont currently has about 186 patient care physicians per 100,000 people, which is below the estimated average of 215 for New England, but is above the estimated national average of 152 (***Figure ES - 6***). In addition, the state has an average of 39 dentists per 100,000 people compared with an estimated national average of 37 and an estimated average for New England of 45. The number of hospital beds per 100,000 people in Vermont (281) is less than the national average (303) but is close to the New England average. However, there are a number of areas in the state designated as Health Professional Shortage areas, which reflects a general mal-distribution of providers within the state.

Lewin estimates that universal coverage would result in an increase in utilization of physician and dental services of 3.7 percent and 4.3 percent respectively. Inpatient hospital utilization would increase by 0.7 percent, while hospital outpatient utilization (excluding emergency room care) would increase by 2.7 percent. Emergency room utilization would actually decline by about 0.9 percent. The cost of this increased utilization would be $23.6 million in 2002.

Figure ES - 6
Physician Supply in Vermont, New England, and the United States per 100,000 People, 1999

State	Patient Care Physicians per 100,000	Dentists per 100,000	Hospital Beds per 100,000
Vermont	186	39	281
New England [a/]	215	45	259
United States [a/]	152	37	303

a/ Estimated.

Source: Estimates provided by the Vermont Department of Health and Lewin Group analysis of the 2001 Area Resource File.

That Vermont has more than the national average of physicians initially suggests that the Vermont health care system could absorb increases in utilization of this magnitude, however the poor distribution of providers within the state would continue to create access problems for many Vermonters.

Cost Shifting

Cost shifting is the practice whereby providers recover the cost of uncompensated care and shortfalls in reimbursement under public programs by increasing prices for private payers. For example, Lewin estimates that payments to hospitals in Vermont under Medicaid and Medicare are equal to about 83 percent and 94 percent of costs respectively. These costs are passed-on to commercially insured people in the form of higher charges. For example, payments for commercially insured people in Vermont, most of whom are covered under employer plans, are projected to be 22 percent greater than costs for these patients. By comparison, payments for the commercially insured nationwide are on average about 13 percent greater than costs.

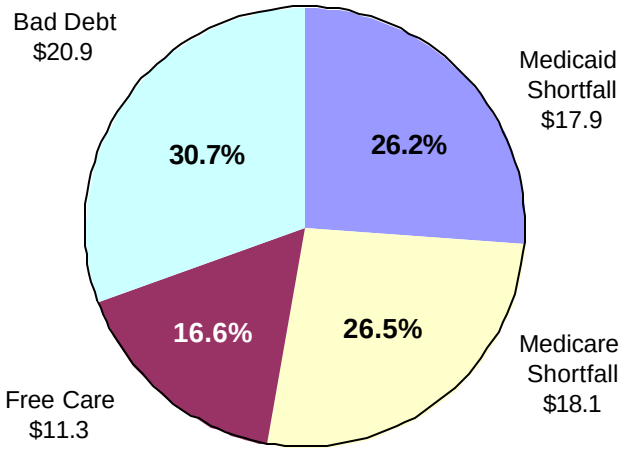
Lewin estimates that the amount of these shortfalls and the cost of charity care and bad debt will be $68.2 million for Vermont hospitals in 2001 (***Figure ES - 7***). However, Medicaid will account for only about 26.2 percent of the cost shift. About 26.5 percent will be attributed to shortfalls in Medicare reimbursement while the remaining 47.3 percent would be attributed to bad debt and charity care. Consequently, reducing the Medicaid cost shift would address only about a quarter of the hospital cost-shifting problem. In fact, eliminating the Medicaid hospital cost shift would reduce hospital payments for privately insured people by only about 3.6 percent.

Options Studied

The options identified by the Steering Committee for consideration under the HRSA grant include:

? Outreach to increase enrollment in existing Medicaid/VHAP/Dr. Dynasaur programs. There are an estimated 20,000 people in Vermont who are eligible for Medicaid/VHAP/Dr. Dynasaur who have not enrolled, of whom 4,900 are children;

Figure ES - 7
Hospital Cost Shift by Source of Shortfall in 2001 (in millions)



Total Hospital Cost Shift = $68.2 million

Source: Lewin Group estimates.

? Income eligibility coverage expansion under VHAP to 300 percent of the FPL for all people including childless adults;

? Permit small employers and individuals living below 300 percent of the FPL to buy in to VHAP by paying a premium equal to the full actuarial cost of coverage. Enables eligible firms and individuals to take advantage of lower provider payment rates and administrative costs under VHAP;

? Buy-in to Employer coverage for Dr. Dynasaur children when cost-effective. The program would enroll eligible children of working parents with access to employer-sponsored coverage in the parent's plan by paying the employee's share of the family premium;

? Employer tax credits for small firms with low-income workers. The credit would be available to all firms with 25 or fewer workers and would be equal to 40 percent of what the employer spends for employee coverage;

? Low-cost coverage option for firms that have not provided insurance in the past 12 months. Creates a benefits package that is free of mandated benefits. Also provides a subsidy to eligible firms (in the form of reinsurance for high cost cases) that effectively reduces premium costs by 10 percent; and

? Single-payer program for Vermont.

Lewin evaluated these plans on the basis of their ability to close the gaps in coverage in the state. The BISCHA survey of households in Vermont indicates that about 91.6 percent of all people in the state have insurance coverage from some source. About 95.8 percent of children are covered

and about 90.2 percent of adults are covered. In addition, about 88.9 percent of Vermonters living below 300 percent of the FPL are insured.

All of the options considered would result in some reduction in the number of people without coverage. However, only the single-payer model would achieve universal coverage. Aside from the single-payer model, the options having the greatest potential impact on coverage were outreach programs to enroll people who are already eligible for VHAP or Dr. Dynasaur who have not yet enrolled. Lewin estimated that an aggressive outreach program could raise the coverage level for children to 97.5 percent and the coverage level for adults in the state to 91.8 percent. Under the outreach option, about 92.8 percent of all people living below 300 percent of the FPL would be covered.

Lewin's analysis indicates that higher levels of coverage could be achieved by combining certain policy options. For example, if the state 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 (***Figure ES - 8***). Adding the VHAP buy-in program would increase coverage for adults to 94.5 percent.

The state 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 fewer 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 (***Figure ES - 9***).

Another approach would be to implement the full range of VHAP expansion and buy-in options together with the employer tax credit and the low cost insurance product. This scenario would reduce the number of uninsured by about 22,200 people, which is equal to about 43 percent of Vermont's uninsured population. Coverage under this combined policy would reach 98.0 percent among children and 95.3 percent among adults. Total state costs would be about $31.4 million, which is equal to about $1,400 per newly insured person.

Direct Health Care Services for the Uninsured

An approach currently operating in Vermont and considered by the Steering Committee is a transitional model of direct "safety net" care designed to provide uninsured people with basic services until a stable source of insurance or financing is available. This service delivery approach of community-based care has been built upon the local commitment of specific health care organizations, their physicians and the community to assure access to health services by all in the community. The direct care model is best exemplified in the "free clinics" that have been established in various parts of Vermont and the Federally Qualified Health Centers (FQHCs) that provide care on a sliding fee scale.

Figure ES - 8
Summary of Cost and Coverage Impacts for Selected Coverage Expansion Options in Vermont

	Number Enrolled	Reduction in Uninsured People	Net New State Costs (in millions)	Percentage of Children Covered	Percentage of Adults Covered	Percentage of People Below 300% FPL Who Are Insured	State Cost Per Enrollee	State Cost Per Newly Insured Person
Current Coverage								
Current Coverage Levels	- -	- -	- -	95.8%	90.2%	88.9%	- -	- -
VHAP Expansion Options								
Expand VHAP to Cover All Adults Through 300 Percent of the FPL	13,000	7,866	$17.3	96.2%	91.8%	91.3%	$1,331	$2,199
Outreach for Children's Coverage (assumes 50 percent effective)	2,457	2,457	$0.7	97.5%	90.2%	89.7%	$203	$203
Outreach for Adult Coverage (assumes 50 percent effective)	7,549	7,549	$9.9	95.8%	91.8%	92.8%	$1,331	$1,331
Buy-in to VHAP for Low-Wage Employers and People Below 300% of FPL	7,668	6,503	$0.0	96.2%	91.5%	90.4%	$0	$0
State Buy-in to Employer Coverage for Dr. Dynasaur Children	832	355	($0.1)	96.0%	90.2%	89.1%	($120)	($391)
Private Coverage Expansion Options								
Employer Tax Credit for Non-insuring Firms with Fewer than 25 Workers Equal to 40 Percent of Employer Costs	6,700	4,416	$5.0	96.5%	90.9%	90.0%	$746	$1,132
Create Low-cost Insurance Option	4,050	4,050	$0.9	96.4%	91.0%	89.5%	$222	$222
Single-Payer Model								
Basic Benefits Model	609,000	51,390	$950.4	100.0%	100.0%	100.0%	$1,559	$18,486

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

Figure ES - 9
Summary of Cost and Coverage Impacts for Selected Combinations of Expansion Options in Vermont

	Number Enrolled	Reduction in Uninsured People	Net New State Costs (in millions)	Percentage of Children Covered	Percentage of Adults Covered	Percentage of People Below 300% FPL Who Are Insured	State Cost Per Enrollee	State Cost Per Newly Insured Person
Current Coverage								
Current Coverage Levels	- -	- -	- -	95.8%	90.2%	88.9%	- -	- -
VHAP Expansion Options								
Expand VHAP to 300 Percent of FPL with Outreach for Currently Eligible Children and Adults	23,024	18,227	$27.7	97.5%	93.6%	94.6%	$1,200	$1,540
ALL VHAP Expansion Options with VHAP Buy-In								
VHAP Buy-In [a/]	25,536	20,373	$27.7	97.8%	94.5%	94.6%	$933	$1,376
Combined Private Sector Options								
Employer Tax Credit with Low Cost Insurance Product	7,510	5,226	$5.8	96.7%	91.1%	89.9%	$772	$1,110
All Public and Private Options Combined								
All VHAP Expansions, VHAP Buy-In, Tax Credits and Low-Cost Product	29,199	22,160	$31.4	98.0%	95.3%	94.7%	$1,075	$1,380

a/ Due to the expansion in eligibility to 300 percent of the FPL, the buy-in would apply primarily to employers.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

The model emphasizes primary and preventive care and provides assistance when needed to access additional care such as specialty care or pharmacy services. In some examples of this approach, patients are integrated into on-going primary care and treatment systems. In other cases, services are provided at the free clinic sites. At FQHCs, comprehensive primary care is provided on a sliding fee scale basis to those without insurance.

This is not a formal "insurance" program, but providers agree to see patients based on local criteria and in free clinics, and have the right to refuse to provide some services or some individuals. There is no "out of area" coverage except as defined by referral arrangements with tertiary care centers. The "direct care model" does not replace existing insurance programs. The Legislature appropriated $300,000 in FY '02 to help support the free clinics.

Single-Payer

The single-payer system differs from incremental approaches in that it represents a fundamental restructuring of health care financing, moving from a mix of public and private funding to a universal, tax based financing system. It has significant implications for the private insurance market, current insurance and coverage arrangements, and offers the guarantee of universal coverage for all Vermont residents. This approach is discussed more completely in the full report.

Recommendations

The Steering Committee met for a daylong session to make final selections of the options and reaffirm the coverage goals that had been implicit throughout the project. There was consensus on the goal of universal access to health insurance coverage for all Vermonters. The public and private sector strategies considered in the State Planning Grant process were primarily directed to people at or below 300 percent of the federal poverty level (FPL). The Steering Committee agreed on interim statewide coverage targets of 95 percent of adults and 97.5 percent of children.

Top criteria for rating the options included cost effectiveness, having identifiable revenue sources, increasing the number of people covered, being administratively simple, not shifting costs disproportionately, and being eligible for Federal matching funds. In addition, options should first focus on providing coverage to lower income Vermonters.

The policy recommendations of the Steering Committee are presented below.

1. In the short term Vermont should direct resources toward maintaining existing levels of coverage

In Vermont, approximately 91.6 percent of all people have insurance coverage from some source. About 95.8 percent of children are covered and about 90.2 percent of adults are covered. Given the bleak short-term economic forecast, Vermont should focus its efforts toward maintaining this existing level of coverage.

2. The target goal of 97.5 percent coverage of children can be met without new program initiatives. The Agency of Human Services should continue current outreach initiatives to eligible children not enrolled in Dr. Dynasaur

The State could achieve the interim enrollment goal for children by increasing enrollment in existing programs, especially Dr. Dynasaur.

3. Coverage should be expanded incrementally based on the State's financial capacity

The Steering Committee's analyses identified that multiple incremental strategies will be necessary to make health insurance available to everyone. State initiatives should focus on uninsured Vermonters at or below 300 percent of the federal poverty level (FPL). Recommended statewide coverage targets for Vermont are defined as 95 percent of adults and 97.5 percent of children and could be reached through a multifaceted approach and a robust economy.

In addition, the Steering Committee made the following recommendations to the Federal government.

1. Maintain the existing commitment of federal participation in 1115a waivers that have achieved coverage expansions

The Vermont Health Access Plan (VHAP) is currently operating under an 1115a Medicaid Research and Demonstration Waiver approved by the federal government in 1995. It is recommended that the federal government (CMS) grant permanency to 1115a expansion populations by considering them part of the Medicaid spending base at the point of consideration of a new waiver, thereby eliminating the need to fund their ongoing coverage through savings under the budget neutrality provision of the 1115a waiver program.

2. The Federal government should create additional tax incentives directed at small employers to encourage the provision of health insurance

The most recent survey of the uninsured underscores that small employers are much less likely to offer health insurance than large employers. The Steering Committee recommends that the federal government use its tax authority to provide incentives to small businesses to cover their employees.

3. Congress should establish a Medicare drug benefit

Vermont and other states have established state programs to provide this essential coverage. Modernization of Medicare through the creation of a drug benefit would potentially make state resources available to either maintain existing initiatives for the uninsured or finance some of the coverage options identified in the Vermont State Planning Grant process.

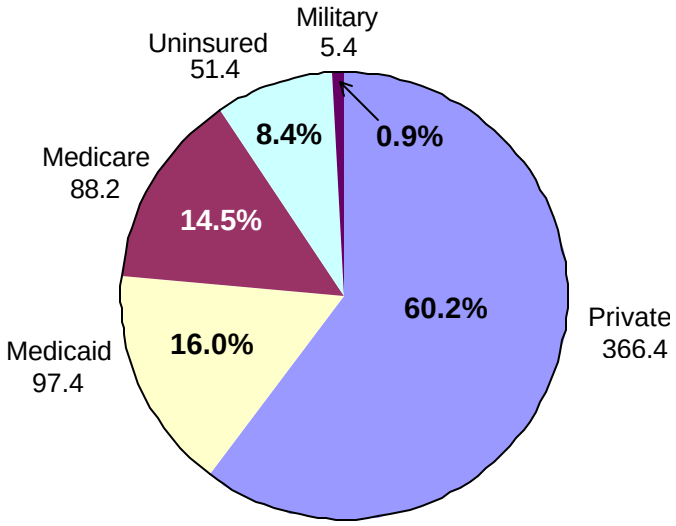
SECTION ONE: UNINSURED INDIVIDUALS AND FAMILIES

This section presents baseline information regarding health insurance in the State of Vermont including a description of the characteristics of the uninsured. Information was obtained from three sources: (1) Vermont Division of Health Care Administration, (2) the Family Health Insurance Survey that was fielded in 2000 by the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), and (3) focus groups conducted with the uninsured by Action Research, Inc.

A. Characteristics of the Uninsured

Out of a total of 608,828 people in Vermont (Census 2000), 51,390 are currently uninsured. Thus, approximately 8.4 percent of all Vermonters are uninsured compared to 14.3 percent nationally. Of those individuals who are insured, more than half (60.2 percent) are privately insured, 14.5 percent are insured by Medicare, 16.0 percent are insured by Medicaid, and less than 1.0 percent are insured by the military (includes dual eligibles) (***Figure 1***).

Figure 1
Primary Source of Health Insurance for All Vermont Residents, 2000 (thousands) a/



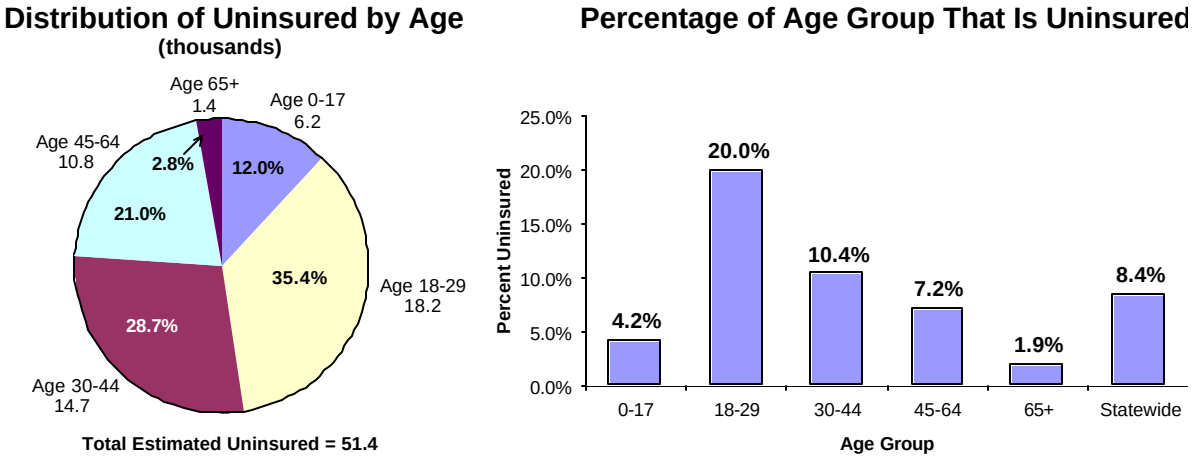
a/ Medicare beneficiaries who are also covered under Medicaid are considered to have Medicare as their primary source of coverage

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

The Vermont Household Survey was designed to include enough survey respondents to develop a statically reliable estimate of the uninsured population in the state. Given the size of the sample, in statistical terms, the true percentage of uninsured, estimated to be 8.4 percent, has a 15 percent change of being between 7.8 percent and 9.0 percent (i.e. the estimate has a standard error of 0.3 percent). This is a substantially smaller range of variation than in prior Vermont surveys conducted by the State and the Bureau of the Census.

Figure 2 (left-hand graph) summarizes the distribution of the uninsured in Vermont by age group. Individuals between the ages of 18 and 29 represented the largest percentage of the uninsured in Vermont (35.4 percent). Children comprise about 12 percent of the uninsured. Nearly all people age 65 and older are insured, primarily by Medicare.

Figure 2
Age Characteristics of Vermont Uninsured, 2000



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

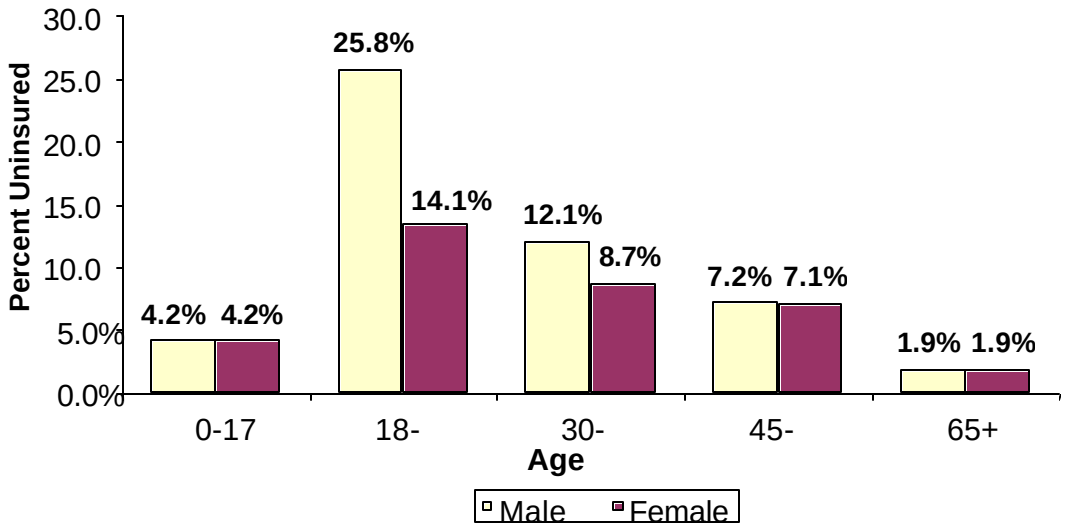
The right-hand side of ***Figure 2*** shows the proportion of uninsured within each selected age group in Vermont. The highest rate of uninsurance, 20 percent, is among adults age 18-29, followed by adults age 30 to 44 at 10.4 percent. Vermont has generally been successful in its attempt to insure all children. Only about four percent of those aged 0-17 are currently uninsured. About 84 percent (4,129 individuals) of uninsured children are youths aged 6-17.

According to the 2000 BISHCA survey, 19,905 Vermonters (3.2 percent) identified themselves as Asian, African, American Indian or mixed race including those whose ethnicity is Hispanic. The rate of uninsurance among this group is 12.9 percent.

Vermont's population is 51 percent female and 49 percent male. The uninsurance rate for females is 7.0 percent and for males it is 9.9 percent. Among those aged 18 to 29, 25.8 percent of males and 14.1 percent of females are uninsured (***Figure 3***). For males aged 30-44, 12.1 percent are uninsured compared to 8.7 percent of females. The lower rate of uninsurance among women reflects the fact that the Medicaid program covers pregnant women.

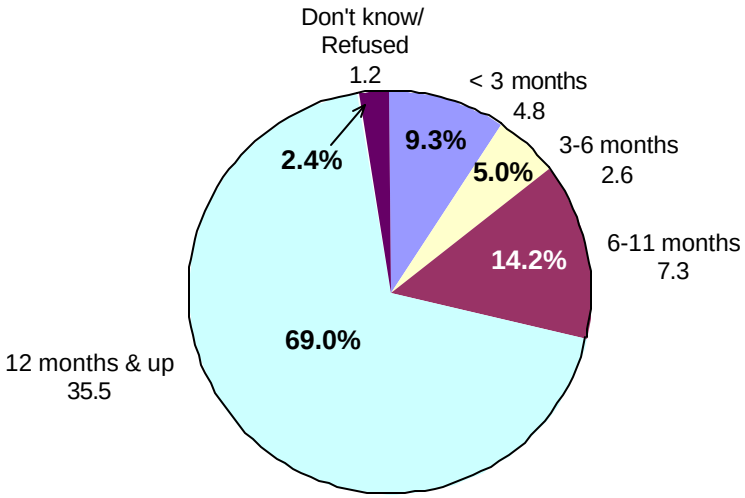
In 2000, approximately 69 percent of the uninsured (about 35,500 people) reported having been uninsured for at least 12 months (***Figure 4***). Of the uninsured in Vermont, 14.2 percent did not have any health insurance for 6 to 11 months, 9.3 percent were uninsured for less than 3 months, and 5 percent were uninsured for 3 to 6 months. More than three quarters (77 percent) of uninsured adults 45-64 had been without health insurance for 12 months or longer. More than two-thirds (67 percent or 4,143) children aged 0-17 had been uninsured for at least one year.

Figure 3
Uninsured Rate by Gender and Age, Vermont Residents, 2000



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

Figure 4
Distribution of the Vermont Uninsured by Duration of Uninsurance, 2000
(thousands)

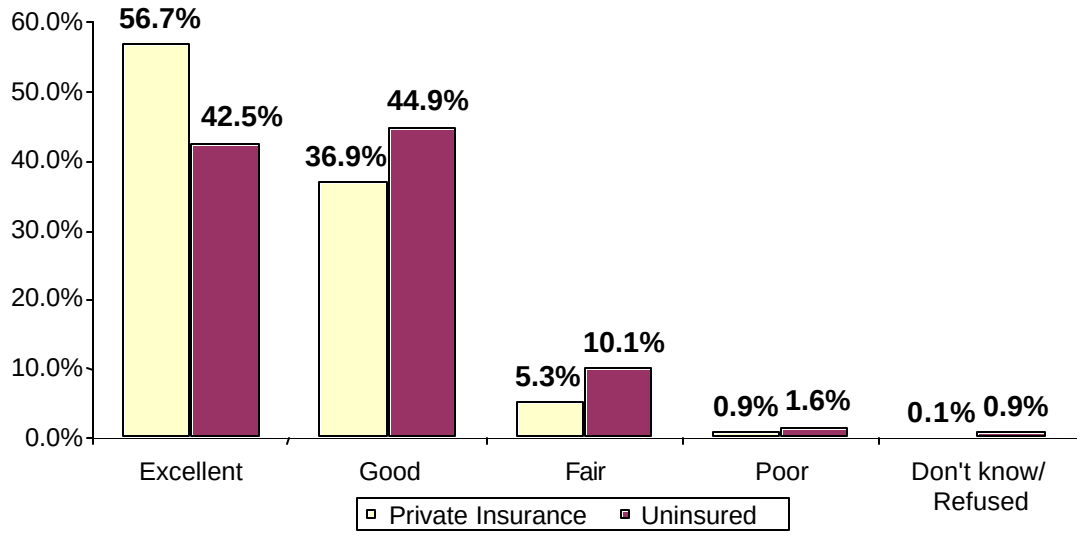


Total Estimated Uninsured = 51.4

Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

The uninsured were more likely to report themselves to be in fair to poor health than insured people. Among those with no health insurance, 11.7 percent reported their health status to be fair or poor as compared to 6.2 percent of people with health insurance (***Figure 5***). Only 42.5 percent of those who are uninsured ranked their own health as excellent as compared to 56.7 percent of those with health insurance.

Figure 5
Self-Reported Health Status Privately Insured vs. Uninsured Residents, 2000



Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

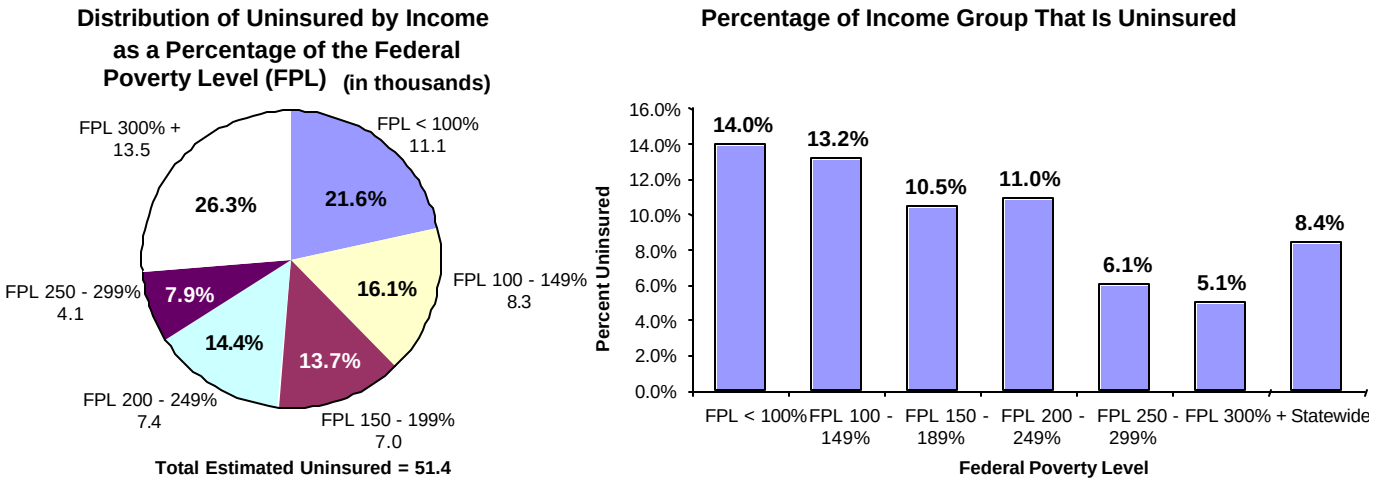
The uninsured include people at all income levels. About 21.6 percent of the uninsured had incomes below the federal poverty level (FPL) (***Figure 6***). Another 29.6 percent had incomes between the FPL and 200 percent of the FPL, while another 22.3 percent had incomes between 200 percent and 300 percent of the FPL. About 26.3 percent of the uninsured had incomes greater than 300 percent of the FPL.

The percentage of people who are uninsured generally declines as income increases (***Figure 6***, right-hand side). The uninsured rate is highest for those below the 100 percent of the FPL (14.0 percent) and lowest for those with incomes above 300 percent of the FPL (5.1 percent). Above 250 percent of the FPL, the uninsured rate improves considerably. The wide distribution of uninsured across income groups suggests that a variety of approaches geared to different income levels may be needed to fully address the uninsured problem in Vermont.

Figure 7 shows how coverage levels vary with income and age. Regardless of income level, younger adults are more likely to be uninsured than older adults. Higher income adults age 18-29 are about as likely to be uninsured as lower income adults who are older. Coverage levels increase with age at all income levels, which may be attributed to increased need for health care and with it a change in perception of the relative value of insurance The Steering Committee

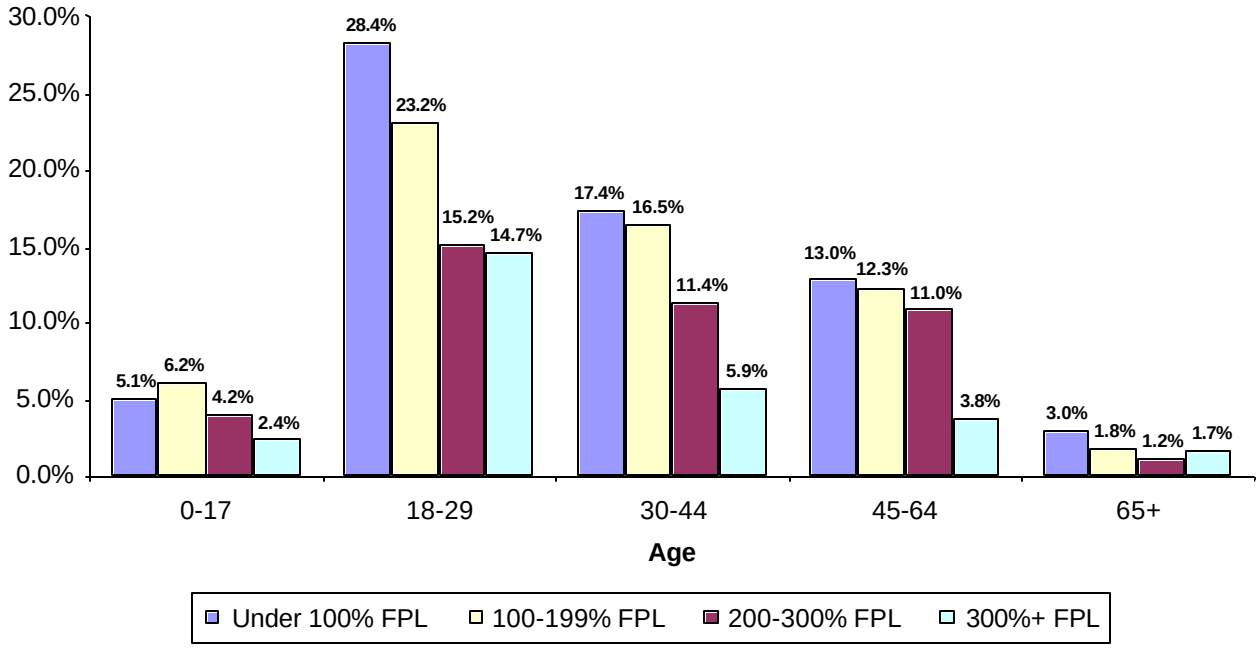
referred to these age groups as "young invincibles" (age 18-29), "Not so young, not so invincible" (age 30-44) and "not immortal after all" (age 45-64. Understanding this combination became extremely important in formulating and evaluating coverage options.

Figure 6
Income (as a Percentage of Federal Poverty Level) Characteristics of Vermont Uninsured, 2000



Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

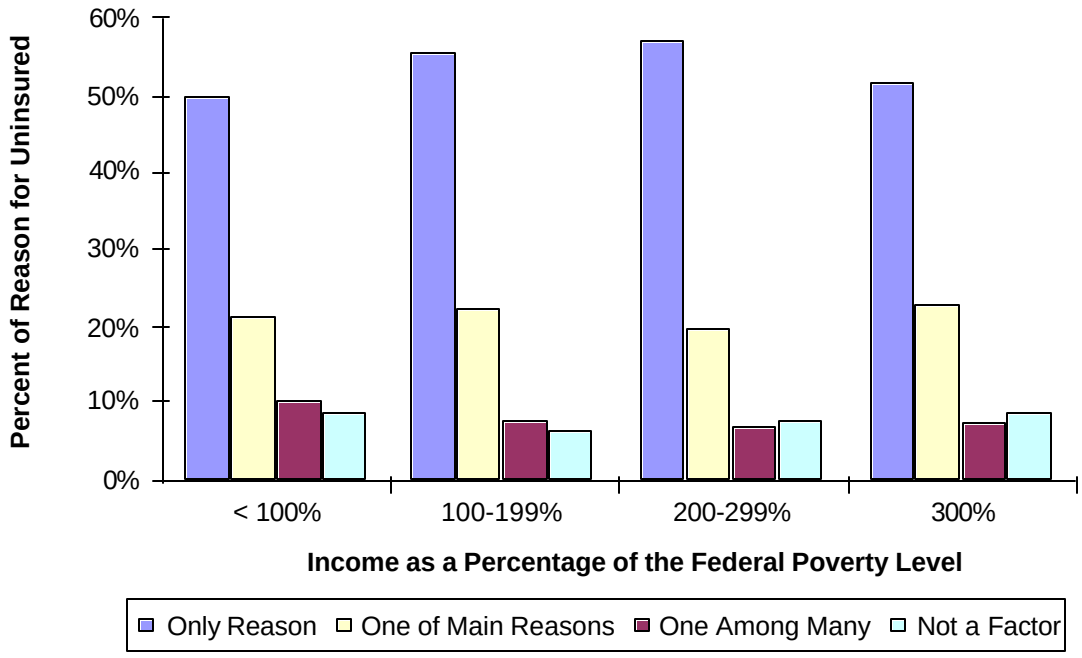
Figure 7
Percentage of Age/Income Group Uninsured
Vermont Residents, 2000



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

Costs are a significant barrier to care, particularly for the uninsured. At least 50 percent of the uninsured in Vermont, regardless of income, reported that cost was their only reason for being uninsured in 2000 (***Figure 8***). Another 25 percent reported that cost was their main reason for being uninsured. Fewer than 10 percent of the uninsured in Vermont reported that cost was not a factor for being uninsured. It is of particular interest that those with incomes over 300 percent of the Federal Poverty Level are as likely to cite cost as a factor in being uninsured as those with incomes less than 100 percent of the Federal Poverty Level.

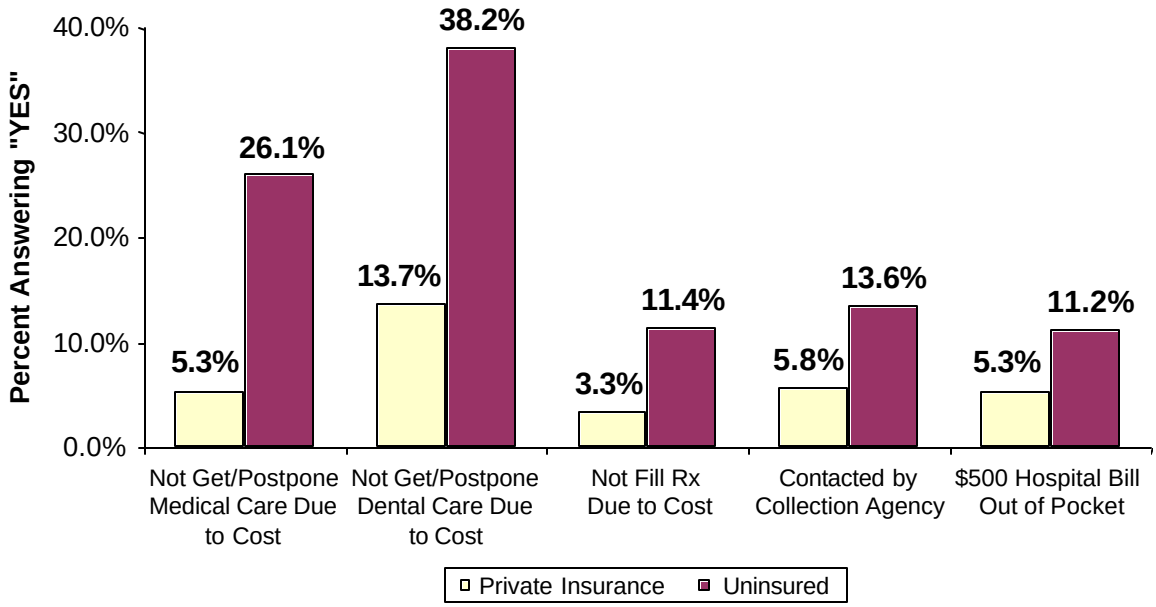
Figure 8
Cost as the Reason for Being Uninsured by Federal Poverty Level, Uninsured Vermont Residents, 2000



Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

Approximately 26.1 percent of the uninsured reported that they either did not get medical care or postponed medical care due to cost barriers compared to 5.3 percent of the privately insured (***Figure 9***). An even greater proportion of the uninsured reported that they would either not get or would postpone dental care due to cost barriers. About 38.2 percent of the uninsured reported that they did not get dental care or postponed dental care due to costs compared to 13.7 percent of the privately insured. A larger share of the uninsured also did not get a refill on their prescriptions due to costs. Many of the uninsured also reported they were contacted by a collection agency about their medical bills, and that they had hospital out-of-pocket expenses in the amount of $500.

Figure 9
Cost Barriers to Care, Privately Insured vs. Uninsured Residents, 2000



Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

B. Focus Group Findings

Focus groups are useful in exploring attitudes and preferences that cannot be revealed through survey research. Two focus groups were conducted with uninsured Vermonters in order to determine why individuals were uninsured and how much they would be willing to pay to have coverage. Additionally, participants' views on how to expand coverage were elicited in these groups. Later in the project, two additional focus groups were conducted with uninsured Vermonters to market test the coverage options that had been developed. In these groups, three plans were discussed in-depth: Medicaid Eligibility Expansion, the Direct Care Model and the VHAP Buy-In to Employer-Sponsored Health Plans. The Employer Health Insurance Tax Credit and the Low-Cost Insurance Plan were also briefly discussed. The focus group reports for both groups are contained in ***Appendix D***.

1. Importance of Health Insurance

All focus group participants agreed that having health insurance is very important for themselves and for their families. 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.

Most participants mentioned that not having health insurance made them uneasy; they worried about what might happen if they were ill or injured. Many acknowledged that they are "gambling with their health." For example, some participants mentioned that they participated in physically demanding jobs, such as landscaping or construction and noted that if they were injured during these activities they would be forced to pay the full cost of their care to a hospital or private physician.

The top five reasons mentioned in the BISHCA survey for not having health insurance were: Cannot afford it (49 percent), Do not qualify for government programs (18 percent), Unsure (9 percent), Employer doesn't offer (7 percent) and, "Lack of information" (5 percent). Reasons for not having health insurance also varied among focus group participants. 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 are 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 cost of purchasing health insurance on their own was cited by nearly all as the reason they are currently uninsured.

Some questioned the "value" of health insurance, citing the relatively high cost compared to what they perceive that they need. Many felt it was more cost-effective to pay when they actually use the service. Others expressed the desire to have a “cafeteria style” plan available so they could select the services that they want and not bother with the rest. A few prefer to use “alternative” providers that are not covered by traditional insurance plans.

2. Cost of Health Insurance

In the BISHCA survey, 75 percent of people without insurance cited cost as the only or main reason for being uninsured. This was supported in the focus groups, where the main barrier also cited was the cost of health insurance plans. The majority of participants are not offered health insurance through their employers and believe they can not afford to buy it privately. Most indicated that premiums above $100 or $150 a month would be too much for them to pay. They feel that a basic plan, with a $1,000 to $2,500 deductible would cost about $300 a month.

Additionally, other expenses such as co-pays and deductibles have a significant role in how much participants are willing or able to pay for insurance. Participants believe that it is less expensive for them pay out-of-pocket for health services than if they were to pay a monthly insurance premium. They feel that if anything major were to happen, they would work out a time-payment plan with the provider.

3. Source of Medical Care

When medical care is needed, focus group participants generally prefer to go to a clinic in their area that offers free or sliding-scale fees for service. Participants indicated that without these clinics, many of the uninsured would not have access to health care or would utilize emergency rooms more often. Several participants said they prefer to seek treatment with private health care providers they know, turning to a clinic only if necessary. They generally do not seek out preventative care, often delay seeking medical care when needed, and have little continuity of care with a single provider.

4. Public Insurance Programs

While these questions were not addressed directly in the focus groups or survey, anecdotal information indicates many of the same reasons for not participating in public programs as in

private: people are unaware that they are eligible and/or may not feel they need health insurance. For the public programs with co-pays, the cost of participation may still be unaffordable or a lower priority expense than other needs. Because some public programs have retroactive benefits, there is little incentive to maintain continuous coverage.

5. Who Should Be Responsible

Most participants believe that the government and employers should be responsible for providing health insurance to Vermonters. However, many participants were wary of a government-only system such as the Canadian-style single-payer program.

6. Participant Recommendations for Expanding Coverage

Participants had a wide variety of recommendations for extending health insurance coverage to more Vermonters. Many of the recommendations include shared responsibility between the state, employers and insurance companies. Many participants recommended expanding the eligibility of existing state-funded health insurance programs. Participants believe this will allow more people to participate in health insurance programs. Participants also recommended the state consider each case individually, taking into account possible mortgage and car payments when looking at income caps.

Participants indicated that the minimum benefit for basic health plan should be coverage of annual physicals, sick doctor visits, prescription drug coverage, emergency care and hospital stays. A few participants stated that annual dental visits and routine dental work also should be covered, and some noted that they would like to see rehabilitation, home health and alternative medical care covered.

7. Impact of Subsidies, Tax Credits or Other Incentives

Participants in both the initial focus groups and the second round (that considered the various options for expanded coverage) provided some information regarding the probable value of various incentives to insurance coverage. Given the strong influence of total cost and perceived value of health insurance, few of these options can be expected to significantly increase the number of insured.

With all of the options, focus group participants expressed concerns about "red tape", complicated applications, and inflexible eligibility standards. There appeared to be a consensus that any subsidy or incentive be "fair". This led to less support for options that targeted sub-groups such as employers that do not currently offer insurance, and more support for broad based options such as expansion of Medicaid to all with incomes less than a set amount. Participants were aware of the cost-shift that occurs when public programs pay less than private for services and were wary of expanding public programs without addressing this problem. There was little support for a low-cost insurance option. The single-payer option elicited strong concerns about costs (increased taxes), quality, choice and an expanded government role in health care.

SECTION TWO EMPLOYER-BASED COVERAGE

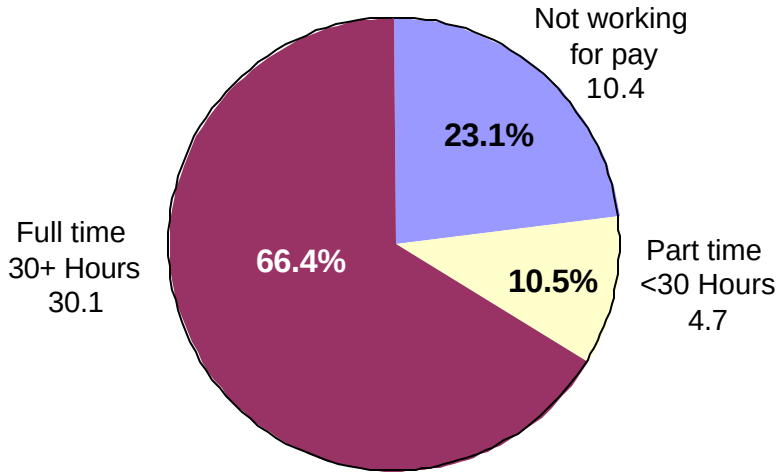
The purpose of this section is to discuss the status of employer-based coverage in Vermont. The bulk of Americans and their families obtain coverage through the workplace, making employers the cornerstones of private health coverage in the United States. It is important, therefore, to gain an understanding from employers about the health insurance they offer in Vermont. This also gives us a basis for designing policy options and effective workplace strategies to expand coverage in Vermont.

There are two major areas covered in this section. First, Lewin provides an overview of employer coverage in Vermont. A discussion of the focus group and key informant interviews is then presented. In this discussion, the factors that influence employers' decisions on whether or not to offer health insurance to their employees are discussed. Employers' ideas regarding possible ways to expand health insurance coverage in Vermont were also obtained.

A. Employer Coverage

According to the 2000 Vermont Family Health Insurance Survey, more than three-quarters of the uninsured population over the age of 18 were employed at the time the survey was fielded in 2000 (***Figure 10***). Out of these uninsured individuals over the age of 18, 66.5 percent were working full-time, 10.5 percent were working part-time, and 23.1 percent were not working for pay (i.e., homemakers, students, retirees, and unemployed).

Figure 10
Distribution of the Vermont Uninsured Aged 18+ by Employment Status, Main Job 2000 (thousands)

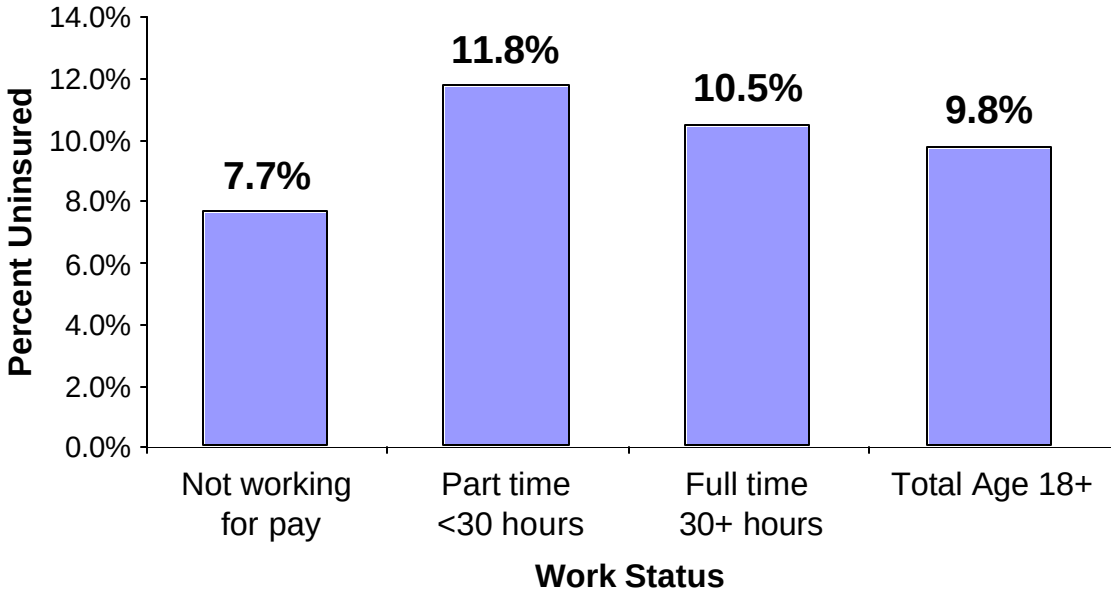


Total Estimated Uninsured Aged 18+ = 45.2

Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

In 2000, almost 10 percent of individuals age 18 and over were uninsured in Vermont (***Figure 11***). Approximately 11.8 percent of part-time employees age 18 and over in Vermont were uninsured compared to 10.5 percent of individuals who worked full-time. Those individuals age 18 and over, who were not working for pay (i.e., homemakers, students, retirees, and unemployed) represented the smallest percentage of the uninsured (7.7 percent).

Figure 11
Uninsured Rate by Work Status, Hours Worked at Main Job, Vermont Residents Aged 18+, 2000

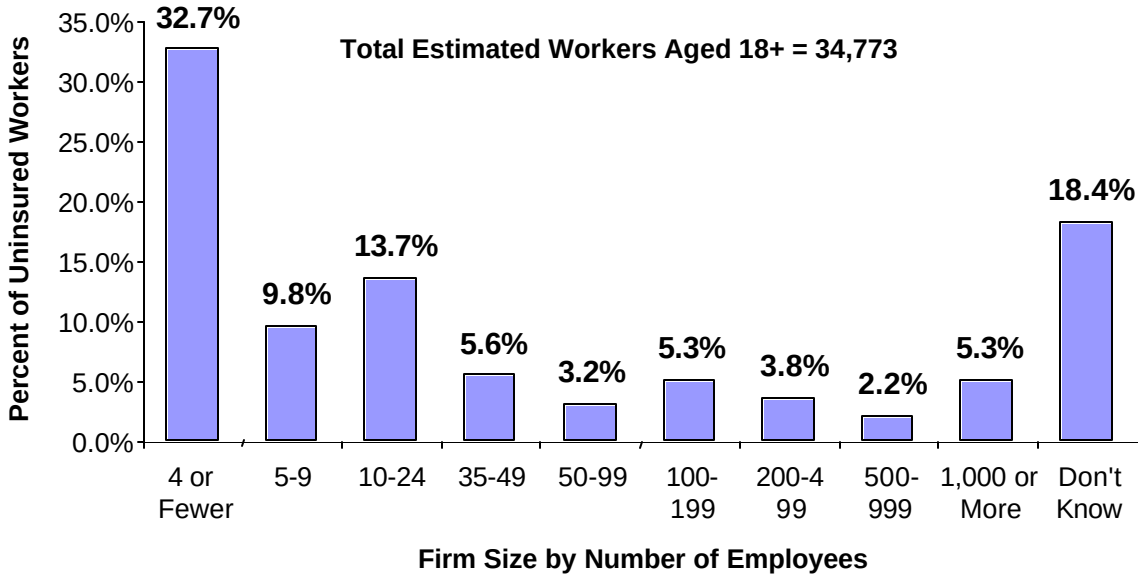


Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

Nearly one-third of uninsured workers reported that they worked for firms with fewer than 5 employees (***Figure 12***). Another 32 percent of uninsured workers are in firms with 5 to 50 employees. Only about 3.3 percent of uninsured workers are in firms with 1,000 or more workers.

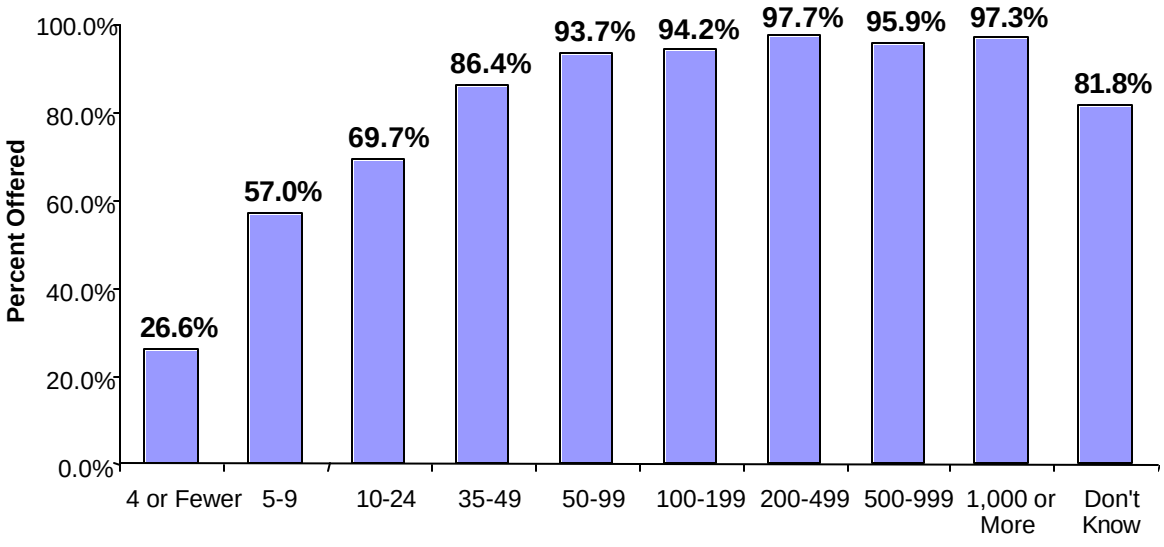
Small firms are least likely to offer coverage. Only about 26.6 percent of workers in firms with fewer than 5 employees are offered coverage through work. By comparison, over 90 percent of employees in firms with over 50 workers were offered health insurance. The proportion of employees offered health insurance increases steadily as firm size increases, and then the percentage increase levels off for firms with over 50 employees at roughly 97 percent. The greatest increase in the percentage of employees offered health insurance occurs between employees who report that they work for firms with fewer than 5 employees and those who report that they work for firms with 5 to 9 employees (***Figure 13***).

Figure 12
Distribution of Vermont Uninsured Workers Aged 18+ by Self-Reported Firm Size, 2000



Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

Figure 13
Percentage of Workers Offered Health Insurance by Self-Reported Firm Size, Vermont Workers Age 18+, 2000



Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

B. Focus Groups and Key Informant Interviews

Sixteen focus group sessions were conducted with employers. Additionally, there were 11 in-depth interviews with employers, resulting in a total of 135 participants. The purpose of the focus groups and interviews with employers was to: (1) identify factors that influence employers' decisions on whether or not to offer health insurance to their employees; and (2) obtain employers' ideas regarding possible ways to expand health insurance coverage in the State of Vermont. Focus group protocols and discussion guides are contained in ***Appendix D***.

Throughout the various employer focus group sessions it became clear that employers who currently offer health insurance and those who do not offer it share very similar views on health insurance and how to expand coverage. Those who offer it reported being very happy to be able to do so, and proud of their health insurance plans. Most of those not offering it reported they would like to be able to offer insurance. All focus group participants, including those not currently offering health insurance, agreed that employers have a social and moral responsibility to offer it. They seemed to believe it is the "right thing to do."

However, nearly all employers in the groups expressed significant frustration with the state of health insurance today and reported having concerns about the future of health insurance. Participants stated that health insurance costs are completely "out of their control," and believe it is impossible to predict, plan or budget for annual health care expenditures.

Few employers currently offering health insurance foresee a time when they will not offer it at all. However, many reported being able to foresee a time when they will need to significantly change the structure of the benefits they offer, either by increasing the employee premium contribution, raising the co-payments or deductibles, or reducing the benefits covered. Small companies were more likely than large ones to report that there might be a time in the future when they could no longer be able to afford to offer health insurance.

Employers who do not offer health insurance identified cost as the primary reason they do not provide coverage. There were several aspects of cost cited by these employers including: premium levels, the unpredictability of costs in the future and the time required to research and administer plans.

1. Perceived Value of Health Insurance

Employers view health insurance as one of the most valuable benefits they can offer, along with paid time off and a retirement savings plan. However, employers were mixed on whether employees value health insurance as a benefit. For example, some employers, particularly those whose workforces consist primarily of young or low-wage employees, agreed that many of their employees would prefer to have paid time off and higher wages rather than health insurance. Several employers indicated that some employees do not value health insurance coverage because they do not fully comprehend what it costs. Participants not currently offering insurance expressed a reluctance to commit to offering health insurance due to rapidly escalating prices.

2. Benefits of Offering Insurance

Employers who offer health insurance said they do so to attract and retain employees. Employers who do not offer health insurance recognize that this has a negative impact on their ability to recruit employees. Other reasons cited for offering insurance include: 1) increasing employee compensation with a tax-free benefit; 2) keeping employees healthy and productive; and 3) having access to group health insurance for themselves.

3. Costs Associated with Offering Insurance

All employers expressed anxiety over high premiums and significant fluctuations in the cost of health insurance. Many employers stated that costs have increased due to state-mandated benefits (e.g., maternity, mental health and chiropractic) and the effects of community rating. Many believe these mandates have caused insurers to leave the state's insurance market, resulting in a lack of adequate competition and in higher prices. Some employers believe that Vermont does not attract many insurance carriers due to its small size. Others noted that local businesses have a difficult time making enough profit to afford health insurance.

Some participants stated they could only afford policies with a large amount of cost sharing (i.e., premium contributions, deductibles etc.) making employee out-of-pocket costs so high that many employees are not willing to participate. Many insuring employers pass on some or all of the cost of premium increases to employees in the form of increased employee premium contributions, reductions in covered services or higher deductibles and coinsurance amounts.

4. Current Offerings

While health plans vary across employers, most employers offer one plan and split the cost of the premiums with their employees. The employees typically pay about 20 percent of the premium.

Employers said that administering benefits for part-time or temporary employees would be difficult due to the variability of the work schedules and thus the uncertainty that the employees will be able to earn enough in wages to pay their portion of the premium. Some employers believe that health insurance is a reward for making a full-time commitment to a company, and therefore do not want to offer the benefit to part-time employees.

5. Market Competition

Many employers indicated that increased insurer competition would be the most important catalyst to reducing premiums despite increasing health care utilization and costs. Employers believe that increasing the number of insurers competing for business in Vermont would reduce insurance costs.

Employers agreed that there is sufficient access to information on health plans, but feel that it is confusing and is not presented in a way that permits comparisons across plans.

6. Who Should Be Responsible?

Most employers believe that it should be the responsibility of employers and the government to ensure that all Vermonters have health insurance. Additionally, most believe it should be: 1) Government's role to create a hospitable environment for insurers to do business; 2) Employers' role to offer health insurance to employees; and 3) Employees' role to maintain their health and refrain from abusing the system.

Other government responsibilities include providing insurance to those who are not able to work and assisting employers who cannot afford to offer insurance to their employees. While employers generally had negative feelings about a "government-funded insurance program", they noted that Dr. Dynasaur is an example of a government program that works well.

7. Employer Focus Group Participant Recommendations for Expanding Coverage

Participants expressed that reducing costs is key to expanding insurance coverage and had several suggestions on how to do so:

? Devise employer tax incentives to encourage more employers to offer insurance;

? Encourage more competition in the health insurance market;

? Develop an affordable, basic (not catastrophic) health insurance plan that is free of state mandated benefits;

? Permit insurers to charge less for groups who utilize less care;

? Form a pool of all people in the state to negotiate favorable rates with providers and insurers.

Additionally, participants suggested that the state should:

? Offer catastrophic health insurance to Vermonters who are without insurance, including part-time and temporary employees;

? Provide understandable plan information to facilitate comparison of coverage alternatives;

? Provide rebates to employees who maintain good health and employers whose groups have good health overall;

? Target individual tax incentives such as Medical Savings Accounts and tax deduction for out-of-pocket medical expenses, regardless of the amount.

A small number of employers recommend that the state require health insurance, either by requiring employers to offer it or by requiring individuals to carry it.

SECTION THREE: HEALTH CARE MARKETPLACE

As part of this project, Lewin conducted a detailed assessment of the Vermont health care system. This included an analysis of trends in health spending by type of service and source of payment. Lewin also performed an assessment of competition in the health care sector and an analysis of cost shifting among hospitals and other providers. In addition, Lewin examined the available data on providers in the state to assess whether there is sufficient provider capacity to meet the increase in demand for health services that would occur among newly insured people under a program of universal insurance coverage.

These analyses were conducted using existing data sources on health services utilization and expenditures in the state. The Division of Health Care Administration provided us with data on health expenditures by type of service and source of payment and detailed hospital utilization and expenditures data. For comparisons across states, Lewin used state level data on health expenditures provided by the Center for Medicare and Medicaid Services (CMS). Lewin also obtained information on hospital spending and services utilization across states from the Medicare hospital cost report data.

In addition to these data analyses, Lewin established two workgroups of industry leaders to advise us on the key issues in the state. These included a workgroup of major insurers serving the state and a separate group of Vermont providers. The results of these analyses are presented in the following sections:

? Health Spending in Vermont;

? Employer Health Spending;

? Cross-State Comparisons;

? Factors Affecting Health Spending Growth;

? Competitive Environment;

? Cost Shifting; and

? Provider Capacity.

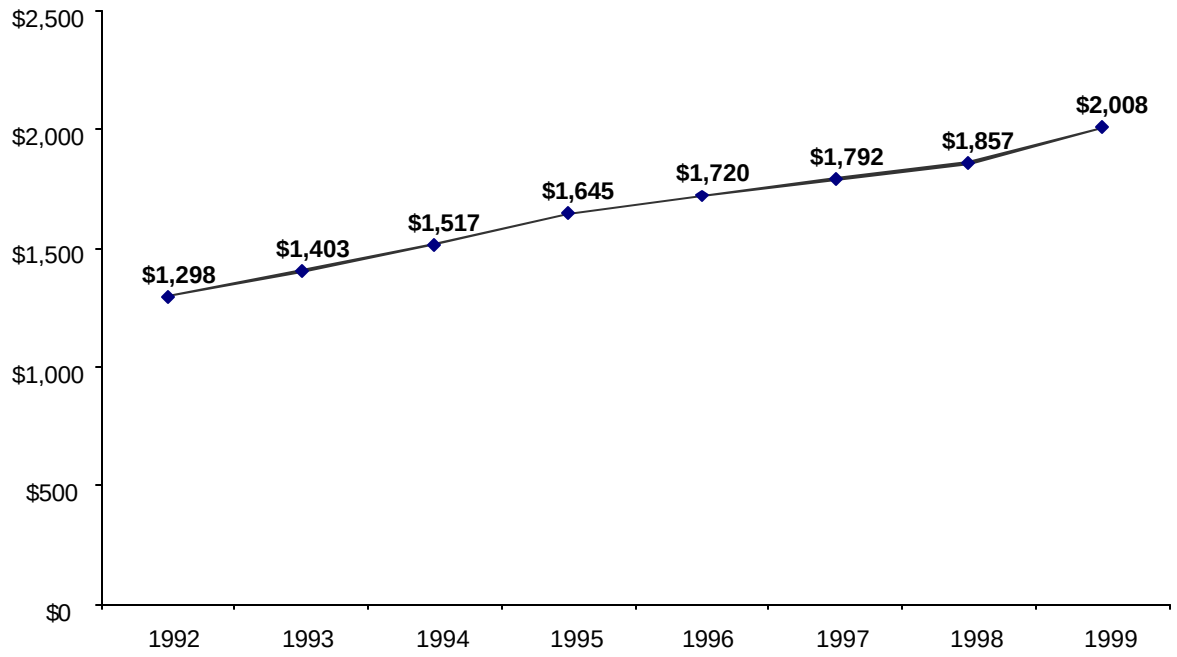
A. Health Spending in Vermont

This section examines health care spending in Vermont. The analyses presented in this section are based upon health spending data provided by the Vermont Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA). These data provide health spending by and on behalf of Vermont residents regardless of where the services are rendered.

1. Statewide Health Spending

Total health spending for Vermont residents increased from $1.3 billion in 1992 to $2.0 billion in 1999 (***Figure 14***). During this period, per-capita health spending in Vermont grew at an average annual rate of 6.2 percent. Total health care expenditures in Vermont include hospital care, physician services, other professional services, drugs and supplies, home health care, nursing home care, insurer/government administration, and government health activities[1]. It also includes services rendered by vision providers, DME suppliers, and other miscellaneous providers.

Figure 14
Trends in Total Health Care Spending in Vermont: 1992 - 1999 (thousands)



Source: Based upon the Vermont Department of Banking, Insurance Securities & Health Care Administration (BISHCA) State Health Expenditures data.

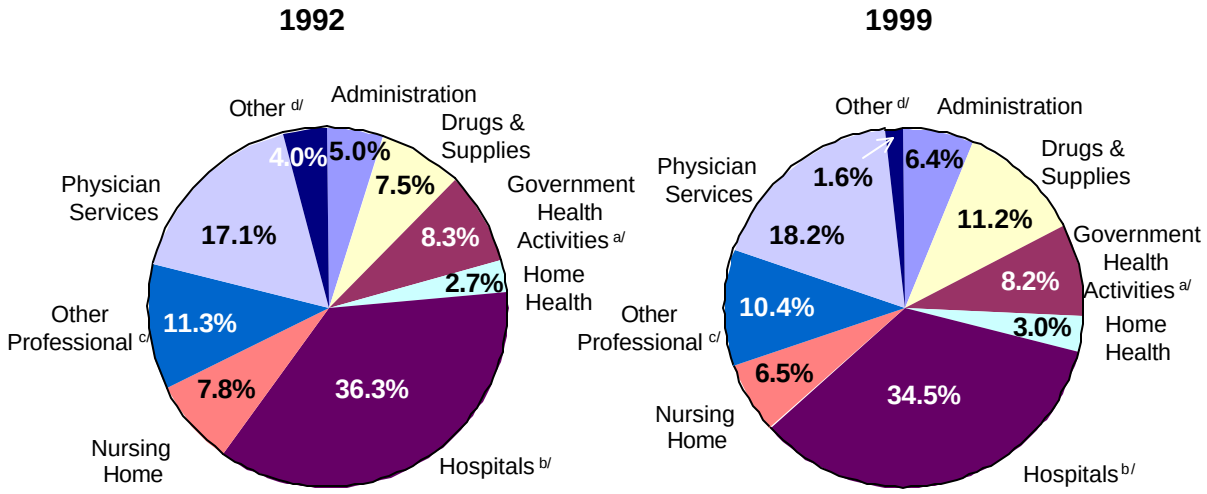
a. Health Spending by Type of Service

Figure 15 compares the distribution of health spending by type of service in 1992 and 1999. Hospital and physician services account for over 50 percent of total health care expenditures in Vermont in 1999. The proportion of health care spending attributed to hospital and nursing home services decreased between 1992 and 1999. During this same period, spending for physician service and home health care services increased as a proportion of total Vermont health

[1] This is the same definition of health spending for Vermont residents used by the Vermont Department of Banking, Insurance, Securities, and Health Care Administration. See: "Vermont Health Care Expenditure Analysis", Vermont Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA).

spending. Similar to national trends, spending for prescription drugs and medical supplies increased as a percent of total health care expenditures.

Figure 15
Vermont Health Spending by Type of Service: 1992 and 1998



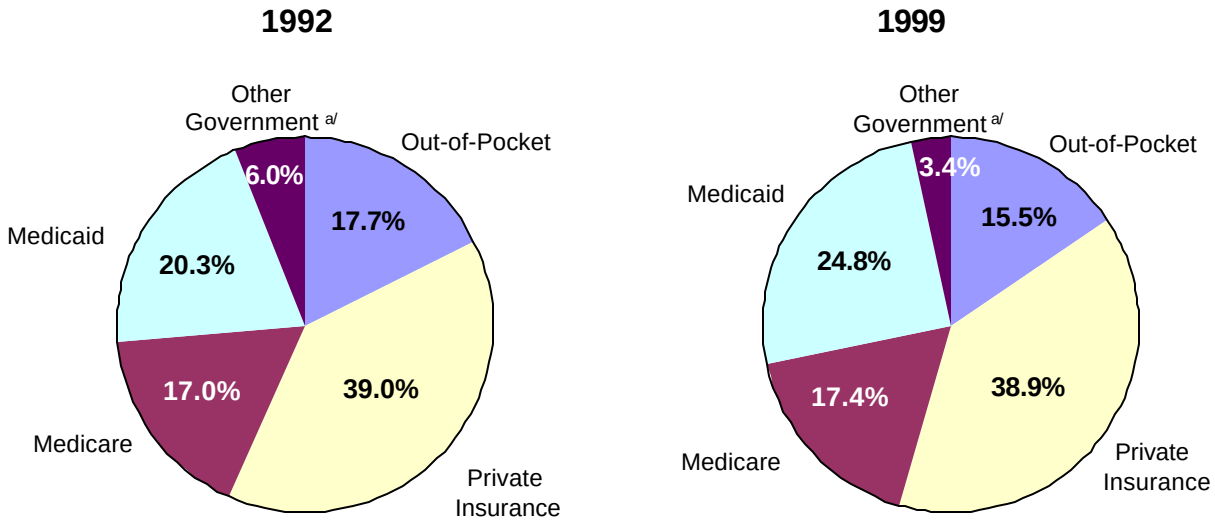
a/ Includes all AHS, Department of Education, Administrative Allocation, and HCA.
b/ Includes community, veterans', and psychiatric (state and private) hospitals.
c/ Includes chiropractor, physical therapy, psychiatric services, podiatrists, dental services, and others.
d/ Includes services rendered by vision providers, DME suppliers and other providers.
Source: Based upon Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) State Health Expenditures data

b. Health Spending by Source of Payment

Figure 16 presents estimates of health spending in Vermont by source of payment for 1992 and 1999. Payments for health care are categorized into five payer sources: out-of-pocket payments; payments made on behalf of policy holders by private insurance; and payments through government programs such as Medicare, Medicaid, and other government sources. [2] Medicaid spending increased from 20.3 percent of total health spending in 1992 to 24.8 percent by 1999 reflecting the expansions in eligibility under the program during that time. The proportion of health spending paid for out-of-pocket by consumers declined from 17.7 percent in 1992 to 15.5 percent in 1999. The proportion of total health spending attributed to Medicare and private insurance was largely unchanged over this period.

[2] Out-of-pocket payment include payments made directly by consumers to providers for unmet deductibles; copayments and non-covered services

Figure 16
Vermont Health Spending by Source of Payment: 1992 and 1999



a/ Includes spending for public health activities by federal or state government that is not covered by Medicare or Medicaid.

Source: Based upon Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) State Health Expenditures data.

2. Trends in Health Spending in Vermont by Type of Service

Total health spending for Vermonters increased by 54.7 percent between 1992 and 1998 (***Figure 17***). Spending for physician services increased by 64.4 percent, while hospital spending grew by only 47.3 percent over this same period. Spending for home health services increased by 71.9 percent during this period while nursing home spending increased by only 29 percent, indicating a shift from nursing homes to home health services in Vermont.

Payments for prescription drugs and medical supplies increased dramatically from $98.0 million in 1992 to $224.8 million in 1999, which is an increase of 129.5 percent over this seven-year period. Also, spending on drugs and supplies has grown more rapidly than any other provider service type during this period. Many factors have contributed to the rapid growth in drug spending, including an increase in drug prices, increased consumer demand for drugs and greater utilization of drugs due to technological advances, and increased direct-to-consumer advertising and marketing of new drugs.

3. Trends in Health Spending by Source of Payment

As shown in ***Figure 17***, Medicaid and Medicare experienced disproportionate growth in spending over the 1992 to 1999 period. While total health spending in Vermont increased by 6.4 percent per year, Medicaid spending increased by 9.5 percent per year over this period. This reflects the growth in eligibility under the program during this period. Medicare spending increased by 7.0 percent per year between 1992 and 1999.

Figure 17
Vermont Health Spending by Type of Service and Source of Payment: 1992 and 1999 (thousands)

	1992	1999	Average Annual Percentage Change
Type of Service			
Hospital [a/]	$471,366	$694,444	5.7%
Physician Services	$221,835	$364,646	7.4%
Other Professional [b/]	$146,066	$208,760	5.2%
Home Health	$34,804	$59,815	8.0%
Drugs and Supplies	$97,967	$224,842	12.6%
Nursing Homes	$100,911	$130,151	3.7%
Government Health Activities [c/]	$107,636	$165,430	6.3%
Other [d/]	$52,390	$56,654	1.1%
Administrative Costs	$65,136	$103,604	6.9%
Total	**$1,298,111**	**$2,008,346**	**6.4%**
Source of Payment			
Out-of-Pocket	$229,361	$312,283	4.5%
Private Insurance	$511,648	$780,747	6.2%
Medicare	$217,770	$349,583	7.0%
Medicaid	$263,137	$497,426	9.5%
Other Government [e/]	$76,196	$68,308	-1.6%
Total	**$1,298,112**	**$2,008,347**	**6.4%**

a/ Includes community, veterans', and psychiatric (state and private) hospitals.
b/ Includes chiropractor, physical therapy, psychiatric services, podiatrists, dental services and others.
c/ Includes all AHS, Department of Education, Administrative Allocation, and HCA.
d/ Includes services rendered by vision providers, DME suppliers and other providers.
e/ Includes spending for public health activities by federal or state government that is not covered by Medicare or Medicaid.
Source: Based upon Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) State Health Expenditures data.

By comparison, private insurance spending grew by about 6.2 percent per year over this period, compared with a growth in total health spending of 6.4 percent per year. This includes employer-sponsored coverage individually purchased non-group insurance and supplemental coverage for Medicare beneficiaries. Interestingly, out-of-pocked spending increased by only 4.5 percent per year over this period, which is substantially less than the growth experienced in the public and private sources of insurance. This is thought to be due to the emergence of managed care plans that have little or no copayments for services obtained from network providers. The slower rate of growth in out-of-pocket spending is also partly due to expansions in Medicaid eligibility that covered services for individuals who otherwise would have been uninsured.

As discussed above, Medicare spending in Vermont grew by an average of 7.0 percent per year between 1992 and 1999 (***Figure 18***). The largest rate of growth in the program was for skilled nursing facility care. Medicare spending for skilled nursing facilities increased by an average of

36.5 percent per year from 1992 to 1999. Home health services increased by an average of 9.1 percent per year from 1992 to 1999. Medicare spending for "other professional" services also dramatically rose from $1.6 million in 1992 to $3.5 million in 1999, which is an increase of 11.3 percent per year. "Other professional" services include chiropractor, physical therapy, psychiatric services, podiatry, dental services, and other miscellaneous providers.

Figure 18
Medicare Spending in Vermont by Type of Service:
1992 and 1999 (thousands)

	1994	1999	Average Annual Percentage Change
Medicare			
Hospital [a/]	$146,552	$213,838	5.5%
Physician Services	$39,704	$64,105	7.1%
Other Professional [b/]	$1,637	$3,457	11.3%
Home Health	$16,664	$30,752	9.1%
Skilled Nursing	$1,937	$17,145	36.5%
Other [c/]	$6,776	$14,002	10.1%
Administrative Costs	$4,500	$6,239	4.8%
Total	**$217,770**	**$349,582**	**7.0%**

a/ Includes community, veterans', and psychiatric (state and private) hospitals.
b/ Includes chiropractor, physical therapy, psychiatric services, podiatrists, dental services and others.
c/ Includes services rendered by vision providers, DME suppliers and other providers.
Source: Based upon Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) State Health Expenditures data.

Medicaid spending in Vermont increased at an average annual rate of 9.5 percent between 1992 and 1999 (***Figure 19***). As discussed below, the growth in Medicaid enrollment was the primary reason for the large increase in Medicaid spending during this period. Prescription drugs and supplies accounted for the largest percentage increase in Medicaid spending (20.4 percent per year) between 1992 and 1999. Home health services had the second largest increase in Medicaid spending during these years (15.9 percent per year), while nursing home care had the lowest increase in Medicaid spending during this time period (3.7 percent per year). Expenditures for physician services increased by an average of 13.3 percent per year, while hospital service costs increased by 5.5 percent per year.

Figure 19
Medicaid Spending in Vermont by Type of Service:
1992 and 1999 (thousands)

	1992	1999	Average Annual Percentage Change
Medicaid			
Hospital [a/]	$59,832	$86,925	5.5%
Physician Services	$16,653	$40,023	13.3%
Other Professional [b/]	$4,724	$13,105	15.7%
Home Health	$6,049	$16,953	15.9%
Drugs and Supplies	$17,172	$63,117	20.4%
Nursing Homes	$59,369	$76,530	3.7%
Government Health Activities [c/]	$74,567	$147,617	10.2%
Other [d/]	$8,611	$12,972	6.0%
Administrative Costs	$16,160	$40,184	13.4%
Total	**$263,137**	**$497,426**	**9.5%**

a/ Includes community, veterans', and psychiatric (state and private) hospitals.
b/ Includes chiropractor, physical therapy, psychiatric services, podiatrists, dental services and others.
c/ Includes all AHS, Department of Education, Administrative Allocation, and HCA.
d/ Includes services rendered by vision providers, DME suppliers and other providers.
Source: Based upon Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) State Health Expenditures data.

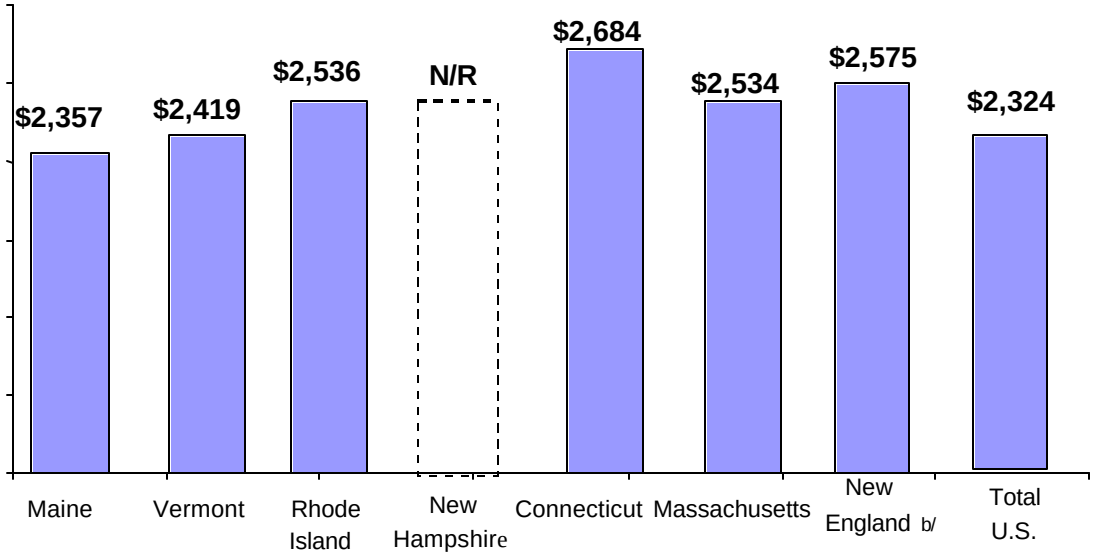
B. Employer Health Spending in Vermont

In this section Lewin examined spending for employer-based health insurance in Vermont compared to the New England region and the nation. Overall, Lewin found that spending for employer-based health insurance in Vermont was very similar to the national average and somewhat lower than average employer-based health insurance spending in other New England states.

The analysis is based upon the 1999 Medical Expenditures Panel Survey (MEPS) data for employers compiled by The Agency for Healthcare Research and Quality (AHRQ). These data provide a sample of about 800 employers in each state. At this time, data on average premiums per worker are available for 40 states including Vermont. These data permitted Lewin to compare health spending per worker in employer-sponsored plans across the nation.

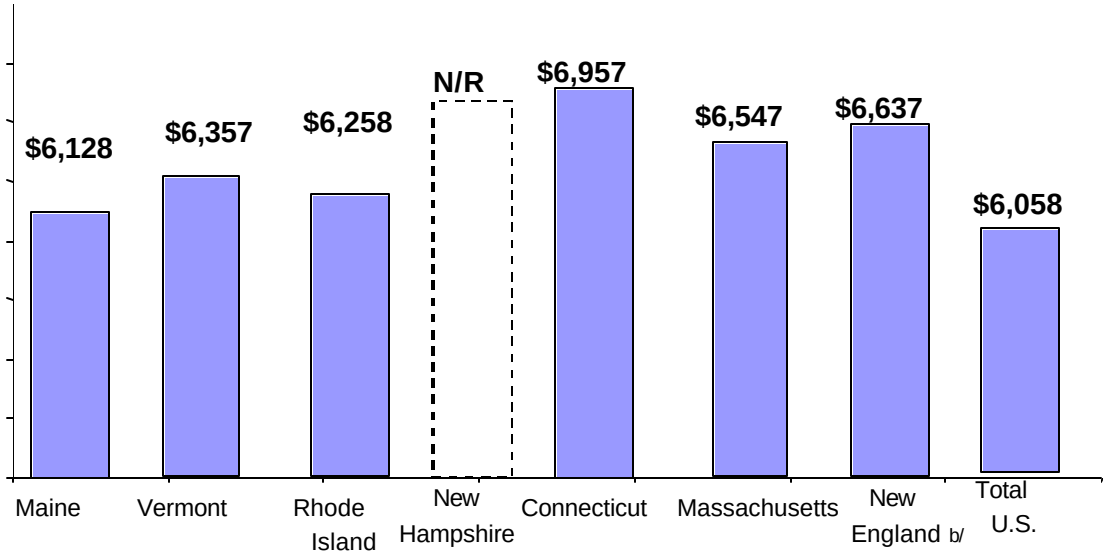
These data provide estimates of average employer-based health insurance premiums for workers in Vermont for single and family coverage (***Figures 20*** and ***21***). The average cost of employer coverage in Vermont (employee and employer share) in 1999 was $2,419 for single coverage and $6,357 for family coverage. This is above the national average of $2,324 for single coverage and $6,058 for family coverage. However, Vermont spending for employer policies is also less than the overall average for the New England states, of $2,575 for single coverage and $6,637 for family coverage.

Figure 20
Average Employer-Based Health Insurance Premium Costs Per Worker with Individual Coverage in 1998 [a/]



N/R- Not Reported
a/ Estimated premium costs include benefits payments and administrative costs.
b/ Excludes New Hampshire
Source: The employer survey component of the Medical Expenditures Panel Survey (MEPS) data for 1999 developed by the Agency for Healthcare Research and Quality (AHRQ).

Figure 21
Average Employer-Based Health Insurance Premium Costs Per Worker with Family Coverage in 1998 [a/]



N/R- Not Reported
a/ Estimated premium costs include benefits payments and administrative costs.
b/ Excludes New Hampshire
Source: The employer survey component of the Medical Expenditures Panel Survey (MEPS) data for 1999 developed by the Agency for Healthcare Research and Quality (AHRQ).

These data have certain limitations. For example, they do not take into account the differences in benefits packages (i.e., covered services, deductible levels, and co-payment amounts) offered by employers across the states. Thus, it is not known whether the differences in employer spending levels across states are due to the level of benefits offered by the employers or other factors such as utilization. It also does not standardize the differences in insurer administrative costs and profit levels across states. Another limitation is that they exclude spending for government workers.

The findings from this analysis are consistent with information received during interviews with benefits managers from multi-state employers with offices in Burlington, Vermont. One of these employers was able to provide cost data for workers in different states. The employer self-insures its employees and uses a third party administrator to manage claims. The benefits manager stated that per-capita health spending for covered employees and their dependents was 'right in the middle' compared to other sites in Texas, California, Seattle and nine other areas nationally.

C. Cross-State Comparisons of Health Spending

This section presents a comparison of health spending trends in Vermont with regional and national trends. Lewin relied on Centers for Medicare and Medicaid Services (CMS) data, which are collected in a consistent manner across states which are suitable for comparisons. However, the CMS data differ from the BISHCA data in three ways.

? **Definition of Health Spending** - The CMS state level spending includes expenditures for personal health services only. The includes spending for all health services including hospital care, physician care, prescription drugs, durable medical equipment, long-term care, and services provided by other providers. However, unlike the BISHCA data presented above, the CMS state level data exclude insurer/government program administrative expenses and public health activities.

? **Reporting by State of Provider** – The CMS data reports expenditures by the state in which services are provided. This differs from the BISHCA data, which is reported by residence of the patient.

? **Reporting of the Data** – The CMS data is available only through 1998 while the BISHCA data is available through 1999.

Despite these limitations, CMS data are the best source of state level health spending information that is consistently defined across states. Consequently, we use the CMS data for cross-state comparisons while using the more refined data provided by BISHCA for our analysis of spending levels in Vermont.

1. Trends in Per-Capita Health Spending

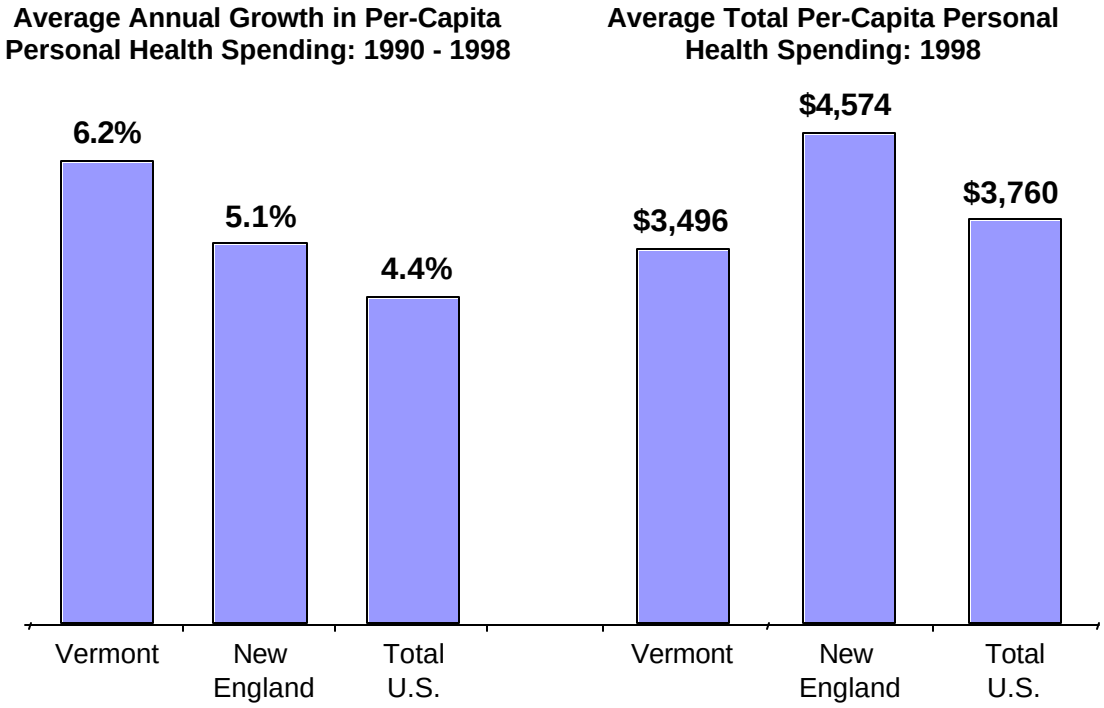
Per-capita health spending in Vermont grew faster than the regional and national average over the 1992 to 1998 period. However, per-capita health expenditures in Vermont were still below per capita spending for New England and the U.S in 1998 (***Figures 22*** and ***23***). Between 1992

and 1998, the average annual growth in per-capita spending was 6.2 percent in Vermont compared to 5.1 percent in New England and 4.4 percent in the U.S. Per-capita health spending in Vermont in 1998 was $3,496 compared to $4,574 in New England and $3,760 in the U.S.

It is important to note the limitations of these per-capita spending estimates. Because CMS reports spending by state of provider rather than the state of the patient residence, our calculation of per-capita spending is equal to total spending provided in the state divided by the number of residents in the state. This will distort the per-capita spending estimate for states were the amount of care provided by in-state providers differs significantly from the amount actually received by state residents (BISHCA estimates that spending for Vermont providers was within 1.5 percent of spending on a resident basis). Thus, per-capita amounts calculated in this way may either understate or overstate the amount of spending per person in each state. However, the changes in per-capita spending from year to year are likely to be more reliable because any bias in the per-capita spending estimate is likely to be similar for each state from year to year.

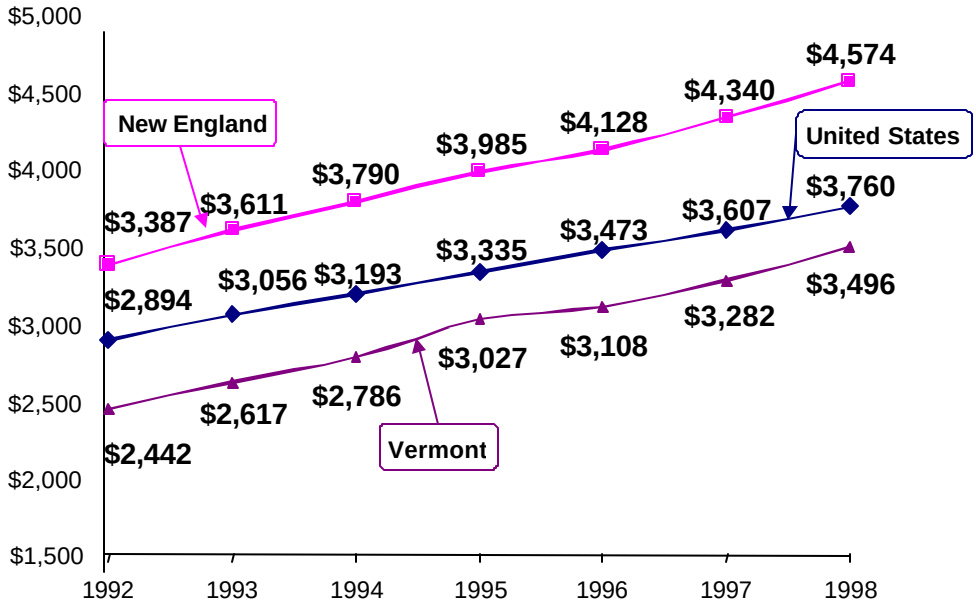
Personal health spending in Vermont increased from 11.1 percent of State Gross Domestic Product (GDP) in 1992 to 12.7 in 1998 (***Figure 24***). Health spending as a percent of State GDP in the New England region declined from 12.5 percent to 12.2 percent during the same period. Similarly, health spending as a percent of GDP in the U.S. declined as well during this period. This reflects both a higher rate of growth in health spending in the state and the fact that State GDP in Vermont has grown more slowly than in other states.

Figure 22
Per-Capita Personal Health Spending in Selected Geographical Regions: 1992 - 1998



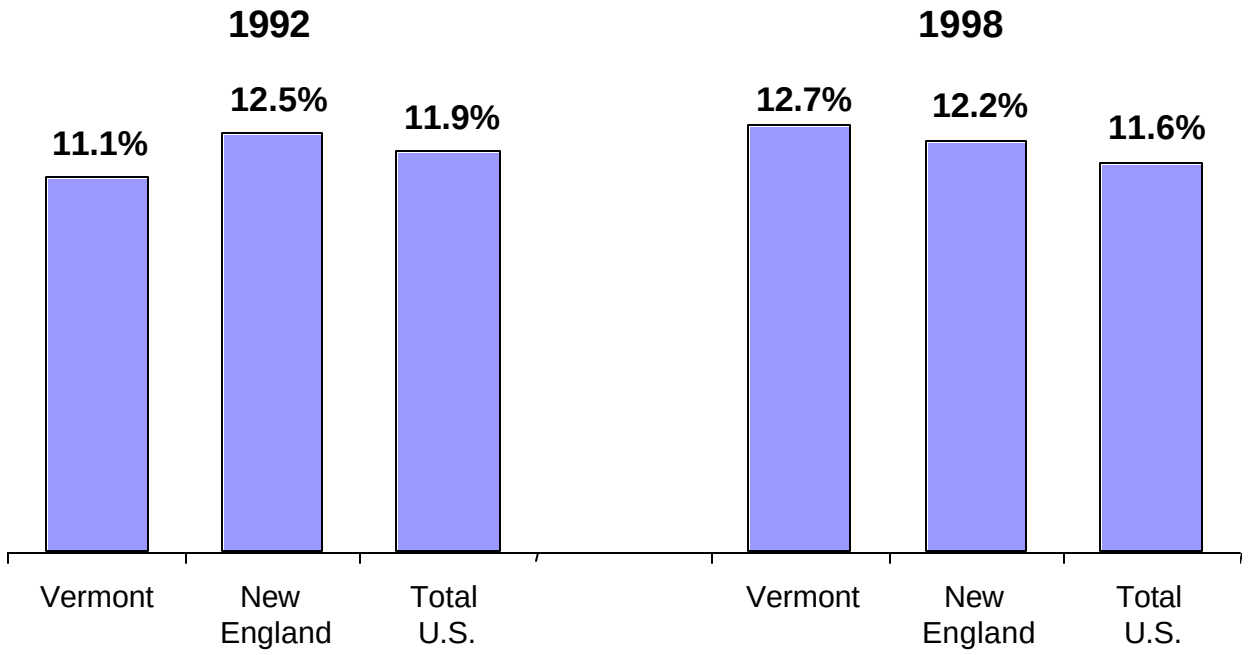
Source: Based upon Centers for Medicare and Medicaid Services (CMS) State Health Expenditures data.

Figure 23
Total Per-Capita Personal Health Spending: 1992 - 1998



Source: Based upon Centers for Medicare and Medicaid Services (CMS) State Health Expenditures data.

Figure 24
Personal Health Care Spending as a Percentage of Gross Domestic Product (GDP) 1992 and 1998



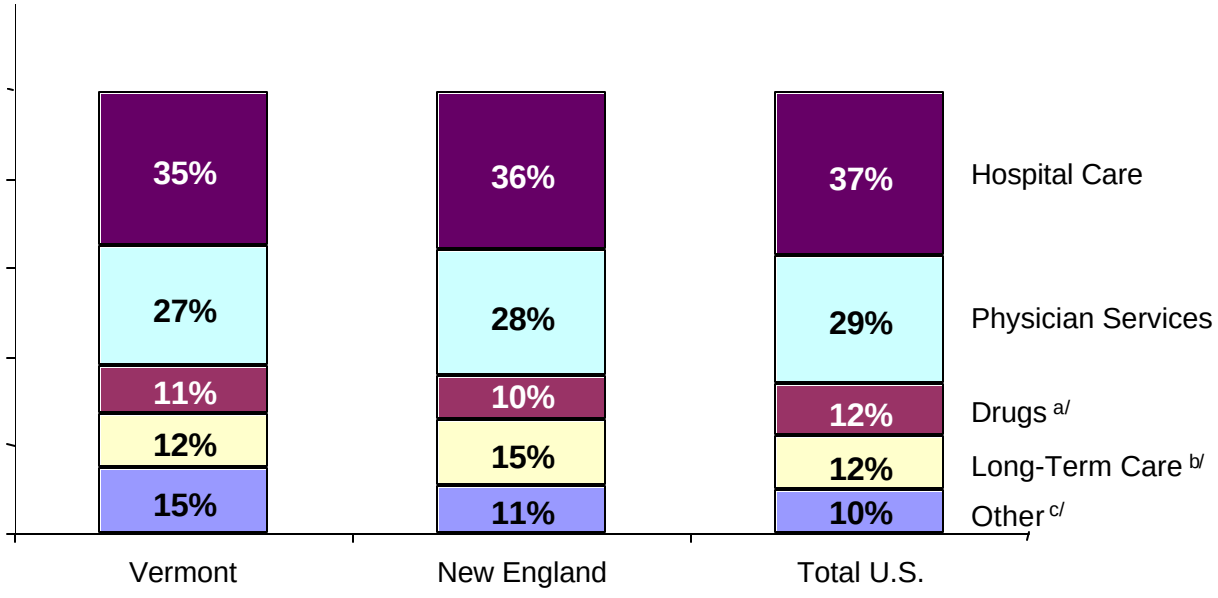
Source: Based upon Centers for Medicare and Medicaid Services (CMS) State Health Expenditures data and Gross State Product data from the Bureau of Economic Analysis

2. Trends in Health Spending by Type of Service

The distribution of health spending by type of service in Vermont was generally similar to the health spending distribution in the New England area and the U.S. (***Figure 25***), Hospitals were the largest provider of health services in Vermont (35 percent), New England (36 percent), and the U.S. (37 percent). Physicians were the second largest provider of services. Both physician and hospital services represented over 50 percent of total health care expenditures in Vermont, New England, and the U.S.

However, health spending growth in Vermont varied considerably from the growth in spending in the New England region and nationally across the various types of services between 1992 and 1998 (***Figure 26***). Spending for hospital, physician, and other professional services in Vermont increased at a much faster rate than in New England and nationally. Spending for prescription drugs and long term care services in Vermont increased at less than the national average. The above-average growth rates for hospital, physician, and other professional services are the primary reason why total personal health care expenses in Vermont have increased faster then the national and regional average.

Figure 25
Distribution of Health Spending as a Percentage of Personal Health Care Expenditures: 1998



a/ "Drugs" includes other medical non-durables.
b/ "Long-term care" includes home health care and nursing home care.
c/ "Other" includes dental services, vision products, and other medical durables, and other personal health care.
Source: Based upon Centers for Medicare and Medicaid Services (CMS) State Health Expenditures data (excludes administrative, research, construction and public health activities).

Figure 26
Average Annual Change in Per-Capita Personal Health Spending by Type of Service 1992-1998

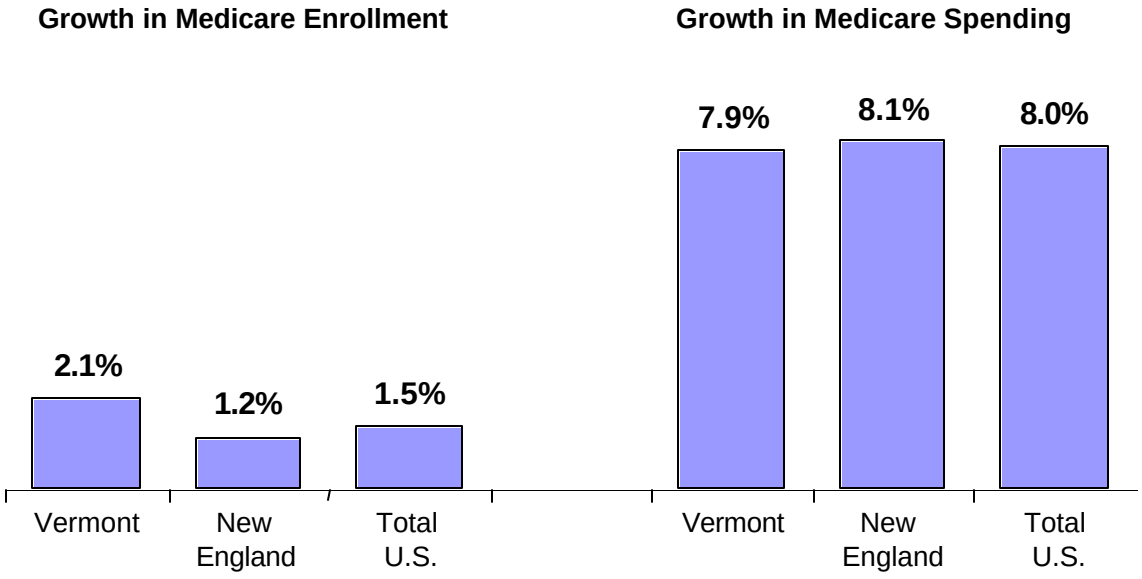
Type of Service	Vermont	New England	Total U.S.
Total Personal Health Care	6.2%	5.1%	4.4%
Hospital Care	4.4%	3.1%	2.9%
Physician & Other Professional Services	7.0%	5.8%	4.2%
Dental Services	6.9%	5.5%	5.4%
Home Health Care	5.7%	6.5%	8.3%
Prescription Drugs	10.7%	11.6%	10.6%
Vision Products & Other Medical Durables	3.3%	3.9%	3.5%
Nursing Home Care	3.1%	4.2%	4.9%
Other Personal Health Care	14.9%	14.2%	12.0%

Source: Based upon Centers for Medicare and Medicaid Services (CMS) State Health Expenditures data.

3. Trends in Spending for Medicare and Medicaid

During the 1992 to 1998 period, the growth in Medicare spending in Vermont was similar to the growth in the New England region and the nation (***Figure 27***). However, Medicare enrollment in Vermont increased at an annual rate of 2.1 percent compared to the 1.2 percent for New England region and 1.5 percent nationally. Between 1992 and 1998, Medicare enrollment in Vermont increased by 13.0 percent compared to 7.2 percent in New England and 9.0 percent nationally.

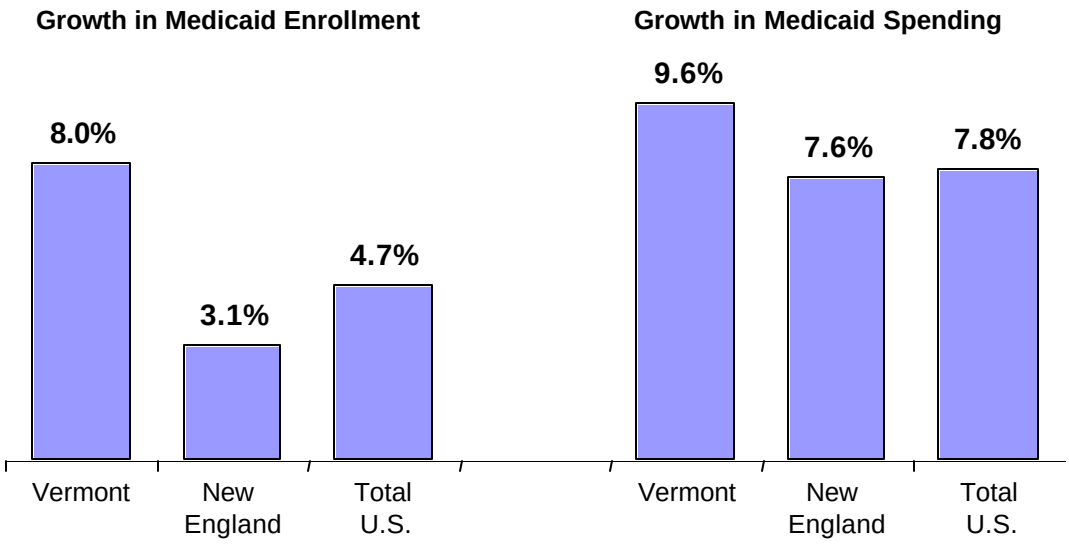
Figure 27
Average Annual Change in Medicare Enrollment and Spending: 1992 - 1998



Source: Based upon Centers for Medicare and Medicaid Services (CMS) State Health Expenditure data.

As discussed above, during the 1992 to 1998 period, spending for Medicaid increased significantly more for Vermont than for the New England and the U.S. (***Figure 28***). Spending in Vermont increased by an average of 9.6 percent per year compared with an average of 7.6 percent in the New England states and 7.8 percent nationally. The increase in Medicaid spending in Vermont is driven primarily by high enrollment growth during that period. Medicaid enrollment in Vermont grew at nearly twice the rate that it grew in the New England area and nationally.

Figure 28
Average Annual Change in Medicaid Enrollment and Spending: 1992 - 1998



Source: Based upon Centers for Medicare and Medicaid Services (CMS) State Health Expenditure data.

D. Factors Affecting Cost Growth

As discussed above, personal health care spending in Vermont increased from $1.4 billion in 1992 to $2.1 billion in 1998. This represents an average annual increase in per-capita health spending of 6.2 percent during this period, which is above the rate of growth in health spending nationally (4.4 percent) and in the New England region (5.1 percent). These increases in spending reflect a range of trends that have affected health care costs such as the aging of the population, utilization increases, changes in technology, wage growth in the health sector, and inflation for medical equipment and supplies.

The purpose of this section is to examine the factors contributing to health care cost growth. Some of the information on the sources of cost growth is available from the Office of the Actuary of CMS (formerly HCFA). Data on population growth and health services utilization is available from other public and private sources. The components of health spending growth are described below. Data on trends in these factors for Vermont are presented where available.

1. Historical Components of Health Care Cost Growth

Research conducted by the CMS Office of the Actuary identifies the factors that have contributed to the historic increases in health spending. These include:

? **Population Growth:** Includes births and immigration.

? **Changes in the Demographic Composition of the Population:** Reflects primarily the aging of the population.

? **General Inflation:** As measured by the Consumer Price Index (CPI) or the Gross National Product (GNP) deflator preferred by some economists.

? **Excess Medical Inflation:** Includes spending increases attributed to changes in provider prices for services.

? **Increased Utilization:** Includes changes in utilization of health services.

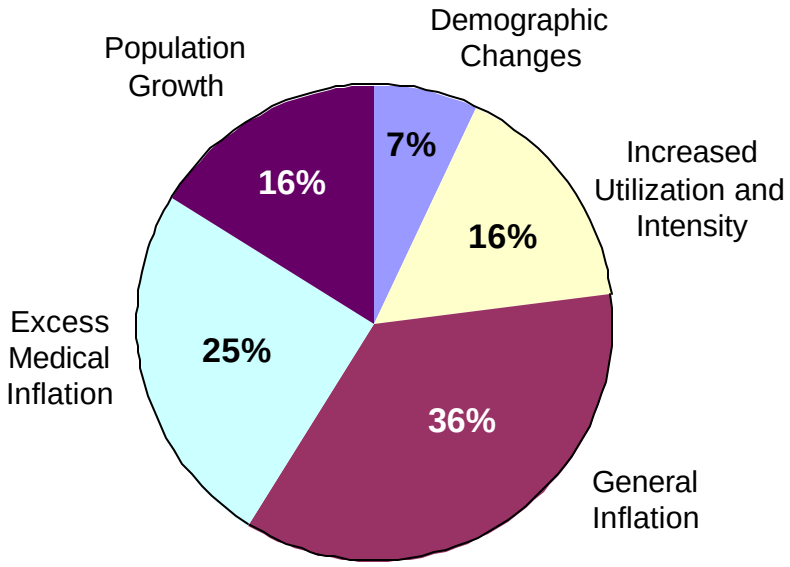
? **Service Intensity:** This is a proxy measure for the growth in medical technology (e.g., new drug therapies, new surgical procedures, etc.).

About 59 percent of health spending growth is attributed to factors that are essentially beyond the control of the health care system itself. For example, 36 percent of cost growth has been attributed to general price inflation as measured by the CPI (***Figure 29***). Another 16 percent is attributed to population growth due to births and immigration. An additional 7 percent is attributed to underlying changes in the demographic characteristics of the population. These include the aging of the population and reflect other factors such as changes in racial/ethnic mix. These sources of growth will continue to increase costs indefinitely regardless of the course of medical technology.

The remaining 41 percent of health care cost growth is attributed to factors related to the practice of medicine itself. About 25 percent of cost growth was attributed to increases in the prices charged for medical goods and services by providers in excess of general price inflation. Another 16 percent of cost growth is attributed to increases in health services utilization and an increase in service intensity.[3] Service intensity is a catch-all term for shifts to more advanced therapies, which is considered to be a proxy measure of the proliferation of new technology.

[3] Critics of these analyses have argued that the method used to measure excess medical inflation probably reflects some of the increase in service intensity due to measurement problems.

Figure 29
Composition of Personal Health Spending Growth 1992-1998



Source: Based upon Centers for Medicare and Medicaid Services, National Health Expenditures data.

2. Impact of Population-Based Changes on Health Spending Growth

Population-based changes in health spending include two factors:

? **Total Population Growth,** which is the annual percentage growth in state population; and

? **Changes in Demographic Mix of the Population,** including the aging of the population and changes in racial/ethnic mix (i.e., increase in average age).

Population growth was less of a factor in spending growth for New England than it was nationally. Over the 1992 through 1998 period, population growth in Vermont accounted for an average annual spending increase of 0.6 percent in Vermont compared with an average of 0.3 percent in the New England states and 1.0 percent nationally (***Figure 30***).

The aging of the population has played a more significant role in health spending growth in Vermont than has been seen nationally or in the New England region. The changes in the demographic composition of the population in Vermont accounted for an additional 0.8 percent annual increase in health spending compared to only 0.4 percent nationally. This is because Vermont includes a proportionally higher share of the baby-boom population when compared to other states (

Figure 31). Thus, Vermont is affected proportionally more as the state's baby-boom population ages into higher health care cost age groups.

Figure 30
Impact of Population and Demographic Changes on Health Spending
1992 to 1998

	Average Annual Change in Population from 1992-1998	Average Annual Impact of Demographic Changes 1992-1998	Average Annual Impact of Population-Based Changes 1992-1998
Vermont	0.6%	0.8%	1.4%
New England	0.3%	0.5%	0.7%
U.S.	1.0%	0.4%	1.4%

Source: Based upon Bureau of the Census data and data from the Centers for Medicare and Medicaid Services (CMS) State Health Expenditures.

Figure 31
Age Distribution for Vermont, New England and the United States, 1999

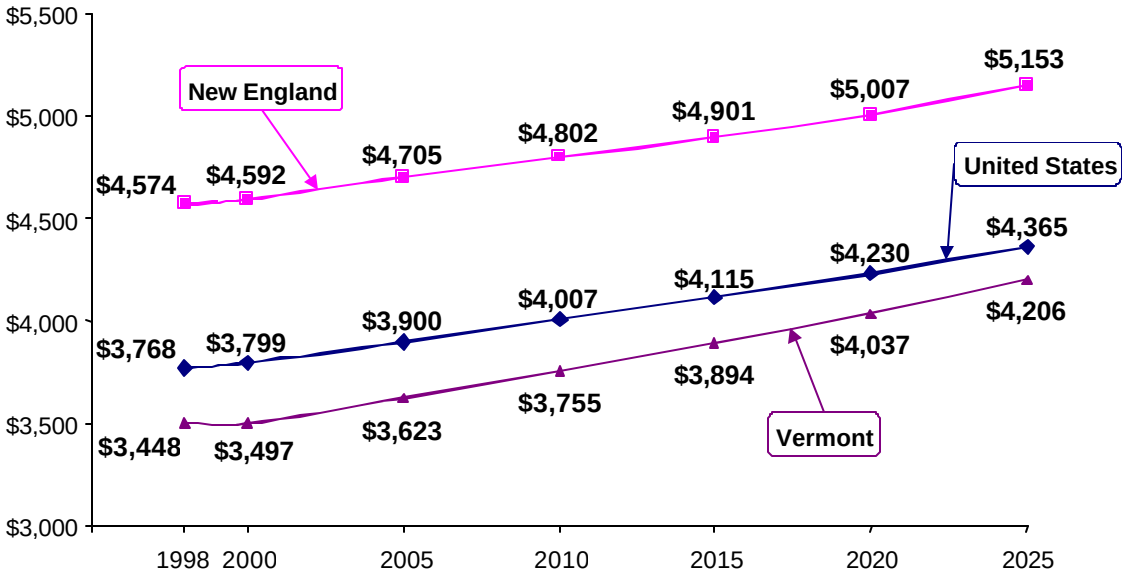
State/Region	Age 0 - 3	Age 4 - 19	Age 20 - 34	Age 35 - 49	Age 50 - 64	Age 65 or Older
Vermont	4%	22%	20%	26%	15%	12%
New England	5%	22%	20%	24%	15%	14%
U.S.	6%	23%	21%	24%	15%	13%

Source: United States Bureau of the Census.

Changes in the demographic composition of the population will have a significant impact on the growth in health spending in future years as the 'baby boomers' age into Medicare. ***Figure 32*** shows per-capita health spending projections for Vermont, New England, and the U.S., holding all factors constant except for the demographic mix of the population. The aging of the population will continue to have a greater impact on health spending growth in Vermont as compared to the New England region and the United States through 2025.

Lewin estimates that demographic changes in Vermont alone will increase per-capita expenditures in Vermont by 22 percent by 2025 even before accounting for inflation and medical technology growth. This compares to a projected increase of 15.8 percent for the United States and 12.7 percent for the New England region over this period. This greater than average cost growth will be particularly burdensome in Vermont because the state's GDP has historically grown more slowly than the GDP of other states.

Figure 32
Change in Per-Capita Health Spending Due to Demographic Changes [a/]: 1998 – 2005



a/ Per capita health spending projections control for changes in the age and sex composition of the population while holding expenditures constant at 1998 levels.

Source: Based upon the Centers for Medicare and Medicaid Services (CMS) State Health Expenditures data.

3. Economy-wide and Excess Medical Inflation

During the 1992 through 1998 period, general inflation averaged about 1.9 percent annually. This accounted for about one-third of the total increase in health spending over this period. Excess medical inflation is the increase in prices for a market basket of medical goods and services that is over and above economy-wide inflation. During the 1992 through 1998 period, excess medical inflation averaged about 1.1 percent and accounted for 25 percent of the increase in health spending.[4]

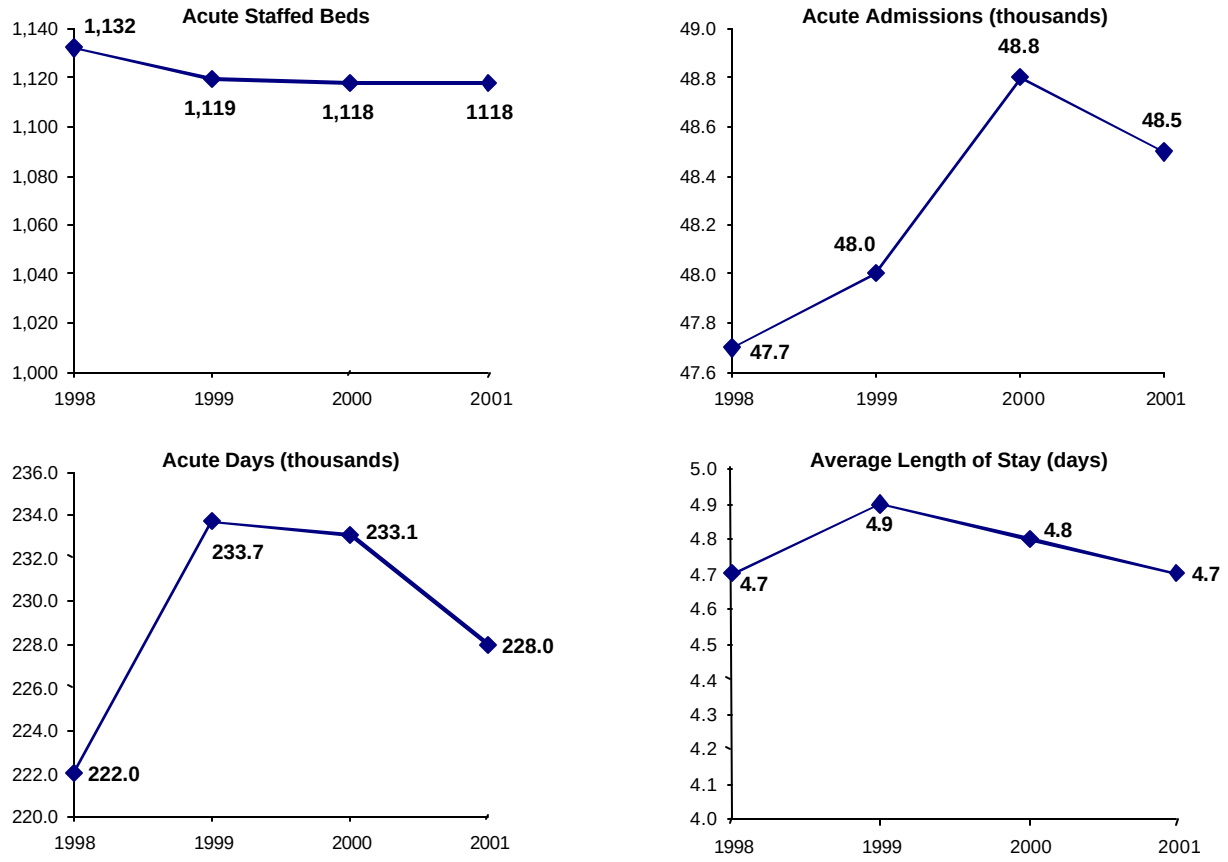
Estimates of excess medical inflation are not available separately for Vermont. However, we do know that there is less use of managed care in Vermont than elsewhere. This is important because areas with wide use of selective contracting and managed care have been shown to have lower rates of growth in health spending (discussed above).

[4] One criticism of the CMS estimates is that due to data limitations, excess medical inflation may reflect the shift to more intensive therapies rather than a change in prices for a given set of services, which is what excess medical inflation is intended to measure.

4. Increase in Utilization and Service Intensity

As part of the hospital budget review process, BISHCA collects extensive information on trends in hospital capacity and utilization. Since 1998, hospital inpatient capacity in Vermont has remained stable at about 1,120 beds (***Figure 33***). Inpatient admissions and days have increased slightly since 1998, which reflect a nationwide trend towards a small increase in inpatient admissions. Length of stay has generally declined slightly in Vermont from 4.9 days in 1994 to 4.7 days in 2001.

Figure 33
Inpatient Utilization Trends in Vermont: 1998 - 2001



Source: Based upon "Vermont Community Hospitals Financial and Statistical Profiles", Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) State Health Expenditures data.

A comparison of hospital inpatient utilization in Vermont to the other regions shows that utilization rates for acute care inpatient services (admissions and days) declined faster for Vermont hospitals than nationally and in New England from 1995 to 1999 (***Figure 34*).** However during that same period, hospital outpatient visits increased substantially more in Vermont than for New England hospitals and the nation. The increase in hospital outpatient utilization may be associated with hospitals purchasing physician groups in the state.

Figure 34
Acute Care Hospital Utilization Statistics 1995-1999

Utilization Statistic	Vermont	New England	Total U.S.
1999			
Acute Hospital Admissions per 1,000 People	85	109	117
Acute Hospital Inpatient Days per 1,000 People	456	584	608
Acute Hospital Adjusted Admissions per 1,000 People	156	188	177
Emergency Room Visits per 1,000 People	371	429	365
Other Hospital Outpatient Visits per 1,000 People	2,010	1,871	1,452
1995			
Acute Hospital Admissions per 1,000 People	94	113	116
Acute Hospital Inpatient Days per 1,000 People	534	668	666
Acute Hospital Adjusted Admissions per 1,000 People	164	174	166
Emergency Room Visits per 1,000 People	365	434	361
Other Hospital Outpatient Visits per 1,000 People	1,427	1,547	1,216
Average Annual Percent Change 1995-1999			
Acute Hospital Admissions per 1,000 People	-2.5%	-0.9%	0.1%
Acute Hospital Inpatient Days per 1,000 People	-3.9%	-3.3%	-2.2%
Acute Hospital Adjusted Admissions per 1,000 People	-1.2%	1.9%	1.6%
Emergency Room Visits per 1,000 People	0.4%	-0.3%	0.3%
Other Hospital Outpatient Visits per 1,000 People	8.9%	4.9%	4.5%

Source: Lewin Group analysis of the AHA Hospital Statistics 2001 Health Forum LLC.

The available data indicates that Vermont's use of hospital services overall is actually less than the national average. ***Figure 35*** presents estimates of the average number of "adjusted hospital admissions" per 1,000 people for selected states and regions. Adjusted hospital admissions are a composite measure of hospital utilization that reflects the use of both inpatient and outpatient hospital care. It is computed as the sum of inpatient admissions and a count of outpatient visits converted to "inpatient equivalent" units of hospital utilization. This measure is useful in comparing hospital utilization in areas where practice patterns may differ in terms of the emphasis placed on inpatient and outpatient care.

These data show that average adjusted admissions in Vermont were 169, compared to a national average of 190 and an average of 201 for New England. Vermont ranked 14th highest among the states in terms of adjusted admissions per 1,000 people. When we adjusted these data to reflect differences in the age and sex composition of state populations, Vermont is ranked only 10th highest among the states. These data indicate that while outpatient utilization in Vermont is growing faster than the rest of the nation, the actual level of utilization in the state is less than that in most other states.

Figure 35
Adjusted Hospital Admissions per 1,000 People by State

State/Region	Adjusted Admissions Per 1,000 [a/]		
	Average	State Rank	
		Unadjusted	Adjusted [b/]
Vermont	169	14	10
New England	201	NA	NA
Maine	207	33	34
New Hampshire	177	17	28
Massachusetts	226	41	30
Connecticut	165	12	9
Rhode Island	212	38	43
U.S. Average	190	NA	NA

a/ Cost per Adjusted Admission is defined as total hospital operating expenses divided by number of adjusted admission. Adjusted admissions is the sum of inpatient admission and equivalent admissions attributed to outpatient services (derived by multiplying admissions by the ratio of outpatient revenue to inpatient revenue).

b/ Adjusted for demographic differences in population by age and gender across state.

Source: Lewin Group analysis of the Medicare Hospital Cost Report Data for 1998 and Health Forum LLC, AHA Hospital Statistics 2001.

5. Coverage Expansions in Vermont

Vermont has implemented expansions in its Medicaid/VHAP/Dr. Dynasaur programs that have reduced the number of the uninsured during the 1990s. The increase in the number of people with health insurance is likely to have resulted in increases in utilization, because insured people utilize more health services than uninsured people (***Figure 36***). Thus, increases in health insurance coverage in the state probably had a direct effect on health spending.

Figure 36
Health Services Utilization for People Under Age 65 by Insured Status [a/] in Vermont

	Uninsured	Insured	Total
Physician Visits per 1,000	1,705	3,650	3,549
Dental Visits per 1,000	565	1,222	1,188
Hospital Stays per 1,000	68	79	78
Outpatient Visits per 1,000	305	484	475
Emergency Room Visits per 1,000	204	188	189

a/ Utilization rates per 1,000 people

Source: Lewin Group analysis using the Vermont version of the Health Benefit Simulation Model (HBSM).

Based on BISCHA data, the proportion of people in Vermont with health insurance increased from 89.2 percent in 1993 to 93.9 percent in 1997. Coverage then declined slightly in 2000 to 91.6 percent. (The increase in the uninsured population between 1997 and 2000 was not statistically significant.) This increase was due primarily to increases in enrollment in the State's

Medicaid program. This compares to national trends indicating that the percent of people with health insurance declined by one percentage point during this same period.

6. Reasons for Higher Cost Growth in Vermont

As discussed above, between 1992 and 1998, per-capita health spending grew by an average of 6.2 percent per year compared with an average of 4.4 percent nationwide. Although there are substantial data limitations the available information provides some insights into why spending in Vermont has grown so rapidly. These include the following:

? **Growth in Outpatient Hospital Utilization:** Per-capita hospital spending grew by 4.4 percent in Vermont over this period compared with a nationwide average of 2.9 percent (see ***Figure 26*** above). Most of the growth in Vermont was concentrated in outpatient hospital services (8.9 percent per year compared with 4.5 percent nationally, ***Figure 34*** above). In fact, inpatient hospital utilization in Vermont grew at a slower rate than it did nationwide.

? **Physician Spending:** Per-capita spending on physician services increased at an annual rate of 7.0 percent in Vermont compared to 4.2 percent nationally over the 1992 through 1998 period (***Figure 26***, above). Unfortunately, the data do not provide the information needed to determine whether this is due to a higher rate of increase in utilization or physician charges.

? **Reduction in Uninsured:** The available data indicate that the percentage of people without coverage declined from 10.8 percent in 1993 to 8.4 percent by 2000. Much of this reduction in the uninsured is attributed to expansions in Medicaid that were implemented in Vermont over the 1990s. The available research indicates that this increase in coverage would have been associated with increased utilization of health services.

? **Demographics:** Vermont includes a proportionally large share of the baby-boom population than in most other states. Consequently, the impact that the aging of this population has had in Vermont is proportionally greater than the national average.

E. Assessment of Competitive Environment in Vermont

An important issue in Vermont is the perceived lack of competition among insurers. The number of insurers serving the state has declined in recent years, and is thought by some to be largely due to the guaranteed issue and community rating legislation adopted in 1992.[5] In addition, there appears to be little competition among providers in the state, which is likely to be contributing to health care cost growth. Competition within the health care system can exist on two levels:

? First, in large markets with many providers, there is usually a great deal of price competition among hospitals and provider groups. For example, hospitals often offer a substantial price discount to managed care plans in exchange for treating a greater volume of patients from those plans. This environment is most likely to exist in areas with several alternative hospitals

[5] "Reviving Health Insurance in Vermont", Ethan Allen Institute, April 2000.

or physician groups, and in areas where there are large numbers of people enrolled in managed care plans where the plan has control over the providers that patients use.

? Second, competition also can occur at the health-plan level. For example, in large markets with many health plans, carriers compete for customers on the basis of price and other factors such as access to providers and the perceived quality of care provided. In this environment, plans are motivated to reduce premiums wherever possible to attract greater market share. This competition can result in improved efficiency in administering benefits with substantial consumer benefit.

The purpose of this section is to assess the degree of competition among insurers and providers in the state. We also evaluate how competition is affected by the various mechanisms used by the state to regulate the health care market place is also evaluated. Lewin's analysis is presented in the following sections:

? Fundamentals of Competition in the Health System;

? Competition Among Insurers in Vermont;

? Competition Among Hospitals in Vermont; and

? The Impact of Health System Regulation on Competition.

1. Fundamentals of Competition in the Health System

Experience in states with highly competitive insurance markets shows that having a large number of insurers in a market area is not enough to result in substantial price competition in insurance. For competition to be effective, there must be a high degree of competition among providers as well. This is because the key to price competition among insurers is their ability to reduce their premiums by negotiating favorable terms with competing hospitals and other providers. Thus, without competition among providers in a market area, insurers can do little to make themselves more price competitive.

For example, consider a city with two competing hospitals. In this environment, an insurer can negotiate volume discounts with one of these hospitals by offering to channel all of their members to that that hospital in exchange for a price discount. The insurer's bargaining leverage in these negotiations is the possibility that if the hospital does not provide a favorable discount, the insurer would take their full volume of patients to the other hospital. The credibility of the insurer's threat to go to another provider is crucial to the insurer's ability to negotiate lower provider prices. The more people covered by the insurer, the greater the bargaining leverage they have with the provider.[6]

[6] Bargaining leverage is also affected by the types of health plans the insurer offers. For example, an HMO typically can require participants to use a specific hospital. This strengthens the plan's bargaining leverage by assuring that all participants would use that provider. Less stringent forms of managed care such as PPO and

By comparison, in a market area with only one hospital, there is no reason for the provider to negotiate favorable terms with the insurer. This is because patients in that market have only one place to get hospital care and will generally serve all of the insurer's hospital patients' in that market regardless of whether they provide a discount to the insurer. This all but eliminates the insurer's bargaining leverage. Thus competition among providers is essential to price competition among insurers. The more competing providers there are in an area, the more bargaining leverage the insurer will have.

Competition can also exist at the physician level. For example, insurers typically create provider networks where the physicians agree to price discounts in exchange for an increased volume of patients. In this model, the insurer is agreeing to channel their full volume of patients to the provider network in exchange for lower prices.[7] Also, health plans often require that network providers participate in their cost containment initiatives such as disease management.

There are several studies showing that selective contracting among competing providers enrollment results in a sustained reduction in the rate of growth in health spending throughout the community. For example, using California hospital cost data, Robinson has shown that the growth in hospital costs was slowed by about 1.5 percentage points per year for every 10 percent increase in selective contracting enrollment.[8] Also, Zwanziger and Melnick found that the growth in exclusive provider networks in California was associated with reduced hospital cost growth.[9] Similar results were estimated from national data by Welch and by The Lewin Group.[10,11] However, it is unclear whether these results are still applicable because of the recent wave of consolidations that has occurred in the health care industry.

The implication of this research for Vermont is that increasing the number of insurers operating in the state would have little impact on premiums. This is because there is not enough competition among providers in the state for health plans to negotiate lower prices through selective contracting and network formation. In fact, as discussed below, the fact that insurers cannot engage in effective hospital selective contracting was cited by some of the insurers that we interviewed as a major reason why there are relatively few insurers operating in the state. Moreover, the lack of provider competition may be a major reason why per-capita health care cost growth in Vermont has been greater than the average growth for the nation and the New England states.

POS only provide financial incentives for patients to use selected facilities, which weakens the insurer's bargaining leverage.

7 In HMOs, the health plan can restrict patients to using only network providers. In PPO and POS plans, the health plan typically encourages the use of network providers by requiring higher patient cost sharing for use of non-network providers.

8 Robinson, J.C., "HMO Market Penetration and Hospital Cost Inflation in California," *Journal of the American Medical Association*, 266 (20 November 1991): 2719-23.

9 Zwanziger and Melnick, "Costs and Price Competition in California Hospitals, 1980-90," *Health Affairs*, Fall 1994.

10 Welch, W.P., "HMO Market Share and its Effect on Local Medicare Costs," HMOs and the Elderly, Health Administration Press, Ann Arbor Michigan 1994.

11 The Lewin Group, Inc., "The Cost of Legislative Restrictions on Contracting Practices: The Cost to Governments, Employers and Families," June 1995.

2. Competition Among Insurers in Vermont

In recent years, insurance coverage in the individual and small group markets has tended to be dominated by two or three carriers. For example, BISHCA data indicate that 72.4 percent of all individually purchased (non-group) coverage in Vermont during 2000 was provided by BlueCross BlueShield (BCBS) of Vermont (***Figure 37***). In fact 99.4 percent of individual coverage was attributed to just the five largest carriers in the market.

There is somewhat greater choice of coverage in the small group market. About 47.1 percent of all small group coverage was provided through the Mohawk Valley Health Plan (MVP). About 97.5 percent of small group coverage was provided by the five largest carriers. In addition, 88.3 percent of all coverage for association health plans, which typically includes smaller businesses, was provided through BCBS.

There are more carriers serving the large group insurance market than the small group market. However, the five largest plans in Vermont still comprise about 97.5 percent of the market, with the largest portion of coverage provided by MVP and BCBS.

A recently available nationwide study of insurance markets permits us to compare the number of carriers serving Vermont with other states in 1997. [12] This study found that Vermont had fewer carriers than other states in New England, which reflects that Vermont is the smallest of these 6 states. The study found that there were a total of 15 carriers serving the group market and 4 serving the individual market in Vermont (***Figure 38***). This compares with 26 carriers serving New Hampshire and Maine, and 55 carriers in Massachusetts at that time. There were 41 carriers in Connecticut and 17 carriers in Rhode Island.[13]

It should be noted that the number of carriers serving Vermont and elsewhere has declined since 1997. For example, New Hampshire now has only about 10 carriers in their small group market. This reflects a nationwide trend of mergers and consolidations that has reduced the number of insurers in these markets nationwide.

There was also a greater dispersion of groups across carriers in states with larger populations. For example, about 90 percent of the group market in Vermont was held by the top three carriers, only 46 percent of the Connecticut market was concentrated amount the three largest plans.

[12] Deborah Chollet, Adele Kirk, Marc Chon, "Mapping State Health Insurance Markets: Structure and Change in the States Group and Individual Markets, 1995-1997" (Report to the Robert Wood Johnson Foundation (RWJF)), Academy for Health Services Research and Health Policy, December 2000.

[13] Includes insurers in large and small group markets.

Figure 37
Comprehensive Major Medical Business by Insurance Sector and Market Type in Vermont: 2000

Carrier	Earned Premium	Lives	Earned Premium Percentage of Total	Earned Premium Cumulative Percentage
Individual (Non-Group) Market				
BlueCross BlueShield of Vermont	$16,632,157	10,222	72.4%	72.4%
Mutual of Omaha Insurance Company	$4,098,700	4,609	17.8%	90.2%
Nationwide Life Insurance Company	$936,002	591	4.1%	94.3%
Fortis Insurance Company	$729,644	61	3.2%	97.5%
MVP Health Plan, Inc.	$444,455	216	1.9%	99.4%
Other Plans	$130,329	308	0.6%	100.0%
Medical - Individual Market Total	**$22,971,287**	**16,007**	**100.0%**	**100.0%**
Small Group Market				
MVP Health Plan, Inc.	$43,546,287	21,163	47.1%	47.1%
Allianz Life Insurance Company of North America	$20,959,321	11,657	22.7%	69.8%
Vermont Health Plan	$16,447,490	7,729	17.8%	87.6%
John Alden Life Insurance Company	$5,243,883	3,834	5.7%	93.3%
BlueCross BlueShield of Vermont	$3,920,818	1,193	4.2%	97.5%
Other Plans	$2,276,025	636	2.5%	100.0%
Small Group Total	**$92,393,824**	**46,212**	**100.0%**	**100.0%**
Association Health Plans				
BlueCross BlueShield of Vermont	$139,625,613	66,621	88.3%	88.3%
Vermont Health Plan	$9,440,525	4,093	6.0%	94.3%
Connecticut General Lifer Insurance Company	$7,846,572	2,247	5.0%	99.3%
John Hancock Mutual Life Insurance Company	$458,455	148	0.3%	99.6%
New York Life Insurance Company	$379,181	182	0.2%	99.8%
Other Plans	$457,320	840	0.2%	100.0%
Association/Trust Total	**$158,207,666**	**74,131**	**100.0%**	**100.0%**
Large Group Plans				
MVP Health Plan, Inc.	$76,108,779	36,988	39.9%	39.9%
BlueCross BlueShield of Vermont	$52,223,029	25,265	27.4%	67.3%
Vermont Health Plan	$34,534,816	15,718	18.1%	85.4%
Connecticut General Lifer Insurance Company	$15,684,939	19,011	8.2%	93.6%
United Healthcare Insurance Company	$7,344,415	3,258	3.9%	97.5%
Other Plans	$4,674,258	17,020	2.5%	100.0%
Large Group Total	**$190,570,236**	**117,260**	**100.0%**	**100.0%**

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

Figure 38
Measures of Competition in Insurance Markets for 1998

State	Total Population (in thousands)	Group Market			Individual Market		
		Number of Insurers	Percentage of Market Held by Three Largest Insurers	Insurers per Million People	Number of Insurers	Percentage of Market Held by Three Largest Insurers	Insurers per Million People
Vermont	591	15	90%	29.5	4	92%	7.9
New Hampshire	1,185	26	49%	24.7	7	65%	6.7
Maine	1,244	26	82%	24.8	9	87%	8.6
Massachusetts	6,147	55	55%	10.6	14	85%	2.7
Connecticut	3,274	41	46%	14.4	12	66%	4.2
Rhode Island	988	17	91%	21.7	4	97%	5.1

Source: Chollet, Deborah J., Kirk, Adele M., Chon, Marc E., "Mapping State Health Insurance Markets: Structure and Change in the States Group and individual Health Insurance Markets, 1995 - 1997," [Report to the Robert Wood Johnson Foundation (RWJF)], Academy for Health Services Research and Health Policy, December 2000.

The same general pattern is evident in the non-group market. The study reports 4 non-group carriers in Vermont compared with 14 carriers in Massachusetts and 12 carriers in Connecticut. About 92 percent of the non-group market in Vermont was covered by the three largest carriers compared with 85 percent in Massachusetts and 66 percent in Connecticut.

One important observation is that in each state there were substantially fewer carriers in the non-group market than in the group market. This reflects the fact that non-group coverage is widely perceived by insurers to be a complicated high-risk line of business. In fact, after the losses sustained by insurers in recent years, there is a general lack of interest among carriers nationwide in pursuing this line of business.

Under the HRSA-funded State Planning Grant, the Steering Committee established a workgroup of representatives of the three largest insurers in the state to better understand the issues from the insurer's perspective. The participants agreed that there is no one reason for the small number of insurers operating in Vermont. Rather, it is a combination of regulatory and market issues. Some of the opinions expressed by insurers are as follows:

? The decline in the number of insurers in the state reflects a nationwide trend of consolidations in the insurance industry and a general reduction in the number of insurers who are interested in staying in the business of health insurance.

? One insurer reported the generally held belief among the insurance industry that for some carriers, Vermont is such a small market that it is not worth the effort or expense to comply with the full range of state regulations. State regulations mentioned include community rating, mental health parity (including the requirement that insurers offering mental health coverage must go through mental health agent licensing) and loss ratio limits. One insurer stated that if it were not for an existing office in the state, that insurer would not be operating in Vermont.

? 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 networks. Insurers that enter the Vermont market must be prepared to compete with existing managed care plans (TVHV and MVP) as well as offer other products, "[it's not possible] to come in and pull off just one market segment".

? One participant said that Vermont's aggressive regulatory environment (including community rating, loss ratio limits, mental health parity) has kept large transnational insurance/managed care companies that do business in Maine from entering Vermont.

? Talk of a single-payer system makes insurers uneasy about investing in Vermont.

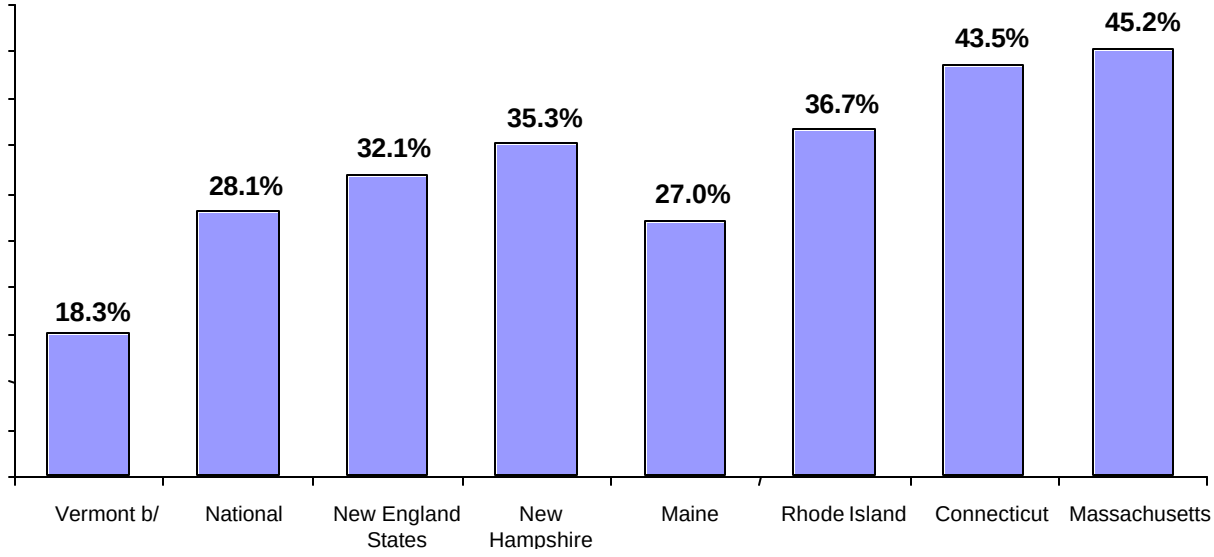
Participants argued that creating competition through more insurers would not necessarily result in better cost control. This is because, as discussed above, health plans do not have the bargaining leverage to force competition among providers, hospitals and clinicians. This makes it difficult to compete on the basis of controlling costs through effective provider networks. Moreover, cost increases in Vermont are driven primarily by utilization, which is difficult to control in a market with few competing providers (i.e., cost control through selective contracting, etc.).

The limited potential for selective contracting in Vermont is reflected in a relatively low level of HMO enrollment in the state. About 18.3 percent of people in Vermont are enrolled in an HMO (***Figure 39***). This compares with an average of 28.1 percent nationwide and 32 percent in the New England states.[14]

It is important to note that not all forms of managed care are precluded by a lack of competition among providers. For example, plans can pay providers a capitated payment amount for each person to cover the full cost of care provided to these patients. Under this model, the providers have an incentive to control spending. Alternatively, the plan could create a "risk-sharing model" where the provider and the health plan share in any savings or losses resulting from care management. These and other approaches have been used throughout the nation in both rural and urban settings.

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

Figure 39
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

3. Hospital Competition in Vermont

In order to assess the competitive environment in Vermont's health care system, Lewin's analysis compares the level of competition among Vermont hospitals to hospitals in other New England area states (Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, and Rhode Island). To accomplish this, Lewin 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 (***Figure 40***). 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 (***Figure 41***) Results from this analysis indicate that Vermont hospitals experience a lower level of competition than other New England hospitals.

Figure 40
Level of Competition Among Hospitals Within a 10-Mile Radius

	Index of Competition			
State	**Low**	**Medium**	**High**	**Total**
Connecticut	**28**	**1**		**29**
Maine	**34**			**34**
Massachusetts	**46**	**4**	**13**	**63**
New Jersey	**34**	**6**	**29**	**69**
New York	**108**	**26**	**52**	**186**
New Hampshire	**25**			**25**
Rhode Island	**7**	**3**		**10**
Vermont	**14**			**14**
Total	**296**	**40**	**94**	**430**

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

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 (***Figure 42***). Vermont ranks 28th in the nation, and has a higher payment-to-cost ratio than the United States average (112.3).

However, 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 41
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).

4. Competition Among Physicians in Vermont

As discussed below, 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.

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 sub-specialists 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 with the very specialists that account for some of the most expensive types of treatments.

There are three other significant 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. Third, the inability of health plans to negotiate selective contracting arrangements with hospitals is sufficiently limiting that it reduces the potential for savings through selective contracting in general.

In 2000, a group that included representatives of state government, the private sector, health plans, and providers issued a Joint Statement on the Health Care System in Vermont. That statement found that physicians do not have the same ability to cost shift that hospitals do. "Both governmental and private payers have established fee schedules, which are rarely subject to negotiation. In some cases, usually Medicare or Medicaid, the fees that are paid are less than the actual cost to provide the service… These physicians may be able to maintain the financial viability of their practices by limiting the number of patients covered by payers who pay less than costs. This limitation can produce access problems for those patients."[15]

[15] Joint Statement on the Health Care System in Vermont, June 1, 2000, page 12

Figure 42
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

According to the Vermont Department of Health in the two years between 1996 and 1998, the percentage of primary care practice sites that accepted new Medicaid patients dropped 5 percent. In the same two-year period, the percentage of pediatricians accepting new Medicaid patients declined from 98 percent to 92 percent. Medicaid access to family practitioners declined from 81 percent to 76 percent and access to internal medicine physicians dropped from 78 percent to 73 percent.[16]

[16] 1998 Survey Report, Health Care Professional Profiles, Vermont Department of Health;
1996 Physician Survey, Vermont Health Care Provider Profiles, Vermont Department of Health

5. The Impact of Health System Regulation on Competition

The state of Vermont regulates several aspects of the health care system, which impacts on the nature of competition in the Vermont health care system. For example, the state has required guaranteed issue of insurance and community rating of premiums in for insurers operating in the state. Insurers are also required to cover certain services under all health plans sold in the state. The state also conducts an annual budget review process for the 14 hospitals in Vermont. In addition, hospitals and nursing homes must obtain a Certificate Of Need (CON) for any major capital improvements or expansions.

a. Mandated Benefits

The state requires plans to cover a range of services under each policy sold in the state. Some of these mandates are in statute and some have been specified by BISHCA under regulatory authority granted by the legislature. These mandated services include maternity care, mental health care and substance abuse care and other services shown in ***Figure 43***. In addition, the state requires mental health parity, which means that mental health services are covered with no greater cost sharing requirements than is required for other services under the plan.

It is generally believed that mandated benefits increase premiums resulting in lower levels of coverage. However, it is difficult to estimate the impact of these mandates. The reason for this is that consumers can respond to these premium increases by purchasing less comprehensive coverage, thus enabling them to continue to have insurance. For example, consumers could purchase a plan with higher coinsurance and reduced coverage for other services to avoid paying a higher premium due to the mental health parity provisions.

One of the insurers interviewed indicated that their data showing that mandatory benefits (e.g., chiropractic and mental health, including the requirement that insurers offering mental health coverage must go through mental health agent licensing) have increased insurance premiums in the state by 5 to 10 percent. Mental health parity is also believed to have had a significant financial impact.

While consumers may have adjusted by changing other aspects of their coverage, it is likely that these mandates have resulted in at least some premium increases. These premium increases are also likely to have caused at least some individuals to drop their coverage entirely. For example, in a recent study of the effect of premium increases on coverage, Lewin estimated that every five-percentage point increase in premiums is associated with a one-percent reduction in the number of people with health insurance.[17]

[17] John Sheils, et al. "Exploring the Determinants of Employer Health insurance Coverage", (Report to the AFL-CIO), 1998

Figure 43
Summary of Vermont Health insurance Mandated Benefits

Requirements	Citation
Rates & Forms Prior Approval	8 V.S.A. §4062
Trust & Association Approval	§4079
Certificates Required (Group only)	§4080(2)
Part Time Employees (Group only)	§4080(4)
Mental Health/Substance Abuse Parity	§4089b
Diabetic Care	§4089c
Disabled Child Coverage	§4090
Continuation & Conversion (Group only)	§4090
Termination & Replacement (Group only)	§4091
Extension of Benefits	§4091
Well Baby Care	§4092
Home Health Care	§4096
Mammography Coverage	§4100
Craniofacial Disorders	§4089g
Metabolic Diseases	§4089e
Maternity Coverage	Regulation 89-1 & Bulletin 114
Chiropractic Coverage	§4088a
Independent External Review	§4089f
Contraceptive Coverage	§4099c
Growth Cell Stimulation Factor	§8079e

Source: Division of Health Care Administration.

b. Insurance Market Regulation

In 1992, the Vermont Legislature enacted legislation to regulate the sale of health insurance in the individual and small group markets. Insurers operating in the state in these markets must guarantee issue of insurance to all applicants regardless of health status. Insurers were also required to adopt a modified community rating process where premiums are equal to the carrier's average costs in these markets.

Premium variation with the health status of the individual was prohibited. Initially, plans were permitted to vary the premium within a range of 25 percent of the average premium by participant characteristics. However, this 25 percent premium variation is currently being phased-out in the small-group market so that all participants would pay the same premium. The insurers interviewed indicated that community rating increased premiums for their younger–healthier groups while decreasing premiums for their older-sicker groups, but had little effect on the overall average premium.

The purpose of community rating is to pool the risk of insurance across the market so that all individuals and small groups can be guaranteed coverage at a uniform premium level regardless of health status. However, there are two ways in which this pooling of risk can be undermined.

? First, employer associations are permitted to offer coverage where the premium is based upon cost experience for the group rather than the community rate; and

? Second, some small groups have been able to self-insure with the help of a reinsurance policy covering high cost cases.[18]

Both the association and self-insured models permit groups with a comparatively healthy workforce to escape the community rate. They also permit employer groups to rejoin the community rated pool once their workforce ages or starts to experience large claims. All of this increases premiums in the community rated pool, thus making it more difficult for other groups to obtain coverage.

The insurers interviewed expressed concern over the effect that self-insurance is having on the community rated pool. One participant said that "selection behavior" has "polluted" the community rated risk pool in Vermont. Despite this problem, these insurers also felt that community rating has helped to "level the playing field" for BCBS and the HMOs. This is because prior to this legislation, BCBS and HMOs were the only health plans required to community rate. Leveling the playing field caused some carriers to think about leaving the state, because once community rating was established, the most desirable target groups weren't as easily accessible.

As discussed above, community rating is only one of the reasons that some carriers left the state. The inability to form competitive networks in the state is a major impediment to competition among health plans. Moreover, the high loss experience of insurers in recent years has led to a reduction in the number of carriers in the individual and small group markets throughout the nation.

c. Hospital Budgeting and Certificate of Need

The state conducts an annual budgetary review for Vermont hospitals and the state must approve all capital improvements and expansions through a Certificate of Need (CON) Process. However, these processes are believed to have done little to control the growth in hospital costs in the state. For example, as discussed above, per-capita hospital spending in Vermont grew at an annual rate of 5.4 percent per year between 1990 and 1998, compared with an annual rate of 4.1 percent in the New England states and 4.0 percent nationwide.

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[18] Under the Employee Retirement Income Security Act (ERISA), states are prohibited from regulating employee welfare plans. This has been interpreted to mean that states are prohibited from regulating self-funded health plans, (i.e., plans where the employer bears the risk for covered services) but are permitted to regulate health insurance (i.e., plans where the insurer bears the risk for covered services). Because larger firms are better positioned to accept risk for covered services, most large employers are self-funded while most smaller groups are fully insured.

A cross-state comparison of hospital costs per adjusted admission showed that Vermont hospital costs were high relative to hospitals in other New England states and the nation. (***Figure 44***). The average cost per adjusted hospital admission was $6,719 in Vermont in 1998, which was second highest in the New England region behind Connecticut ($7,323). The average cost per adjusted admission in Vermont ranked 41st nationally (the state with a rank of one had the lowest cost and the state with a rank of 51 had the highest cost). After standardizing for factors outside of hospital management control (such as population characteristics, percent rural, etc.), Vermont's ranking by average costs per adjusted admission improved to 30. After adjusting for factors outside of the hospital's control, costs in Vermont hospitals are slightly above the median for the nation.

Figure 44
Hospital Margin, Hospital Costs Per Adjusted Admission and Staff Per Adjusted Admission in 1998

State/Region	Hospital Margin 1999 [a/]	Cost Per Adjusted Admission [b/]			Total Staff Per 1,000 Adjusted Admissions		
		Average	State Rank		Average	State Rank	
			Unadjusted	Adjusted		Unadjusted	Adjusted
Vermont	2.5%	$6,719	41	30	76	27	17
New England	2.1%	$6,576	NA	NA	76	NA	NA
Maine	7.2%	$6,311	32	44	77	34	38
New Hampshire	9.4%	$6,118	29	8	76	29	31
Massachusetts	0.3%	$6,447	34	4	76	28	26
Connecticut	2.3%	$7,323	45	25	74	36	28
Rhode Island	-1.9%	$6,539	37	24	73	22	34
U.S. Average	--	$6,243	NA	NA	75	NA	NA

a/ Hospital margin is defined as the difference between hospital revenues and expenses as a percentage of revenues.
b/ Cost per Adjusted Admission is defined as total hospital operating expenses divided by number of adjusted admission. Adjusted admissions is the sum of inpatient admission and equivalent admissions attributed to outpatient services (derived by multiplying admissions by the ratio of outpatient revenue to inpatient revenue).
Source: Lewin Group analysis of the Medicare Hospital Cost Report Data for 1998

However, the relatively high costs for Vermont hospitals was not a result of over staffing. After adjusting for factors outside the hospitals control, Vermont hospital ranked 17th lowest for total staff per adjusted admission. Also, hospital margins in Vermont are generally consistent with margins in other states. For example, the average margin for Vermont hospitals is 2.5 percent compared with an average of about 2.1 percent in the New England States.

Some of the insurers interviewed suggested that Vermont may not need as many hospitals as it has. One insurer representative voiced the opinion that the Dartmouth-Hitchcock and Fletcher Allen systems, along with 2-3 other hospitals, could cover the inpatient service needs in the state alongside a system of urgent and emergency care facilities. Another suggested that having two medical schools in Northern New England may be too many. The insurer representatives

interviewed agreed that it is not the hospital *systems* in Vermont which are the high cost entities but rather the small, rural hospitals.

Workgroup participants generally agreed that changing provider behavior and utilization is the key to cost control. Disease management has been found to be an effective means of controlling beneficiary utilization. The focus for reducing costs in the long term is to influence utilization decisions by providers using: financial incentives (such as "risk sharing"), providing comparison and best practice information, sharing data, disease management strategies, small process interventions, and developing good working relationships with providers.

F. Cost Shifting

Cost shifting is the practice whereby providers recover the cost of uncompensated care and shortfalls in reimbursement under public programs. The cost shift occurs in three ways. First, uninsured people who do not pay for their care often create an uncompensated care burden for providers that is passed on to other payers, primarily employer group plans, in the form of higher charges. Second, some insured individuals fail to pay coinsurance amounts resulting in bad debt expenses. Third, reimbursement levels under public program such as Medicare and especially Medicaid are often less than the cost of services provided causing payment shortfalls that result in higher charges for privately insured people.

1. Measuring the Cost Shift

The literature is mixed on the magnitude of the cost shift. One possibility is that hospitals and physicians pass on the full amount of uncompensated care and shortfall in public program payments to privately insured people in the form of higher payments (i.e., charges less negotiated discounts). However, there is evidence that not all of these payment shortfalls are passed on to privately insured people. In fact, providers are likely to take steps to reduce costs when faced with payment shortfall. Thus, some of these shortfalls result in a cost shift to the privately insured, while some of it takes the form of reduced spending (e.g., delay capital improvements etc.).

Two independent studies estimated that about half of hospital payment shortfalls are passed on to private payers in the form of higher charges.[19] However, two other studies showed considerably less evidence of hospital cost shifting, although they did not rule out a partial cost shift.[20] One study of physician pricing by Thomas Rice et al., showed that for each one percent reduction in physician payments under public programs, private sector prices increased by 0.2 percent.[21] Our

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[19] Dranove, David, "Pricing by Non-Profit Institutions: The Case of Hospital Cost Shifting," Journal of Health Economics, Vol. 7, No. 1 (March 1998); and Sloan, Frank and Becker, Edward, "Cross-Subsidies and Payment for Hospital Care," Journal of Health Politics, Policy and Law, vol. 8., No. 4 (Winter 1984)

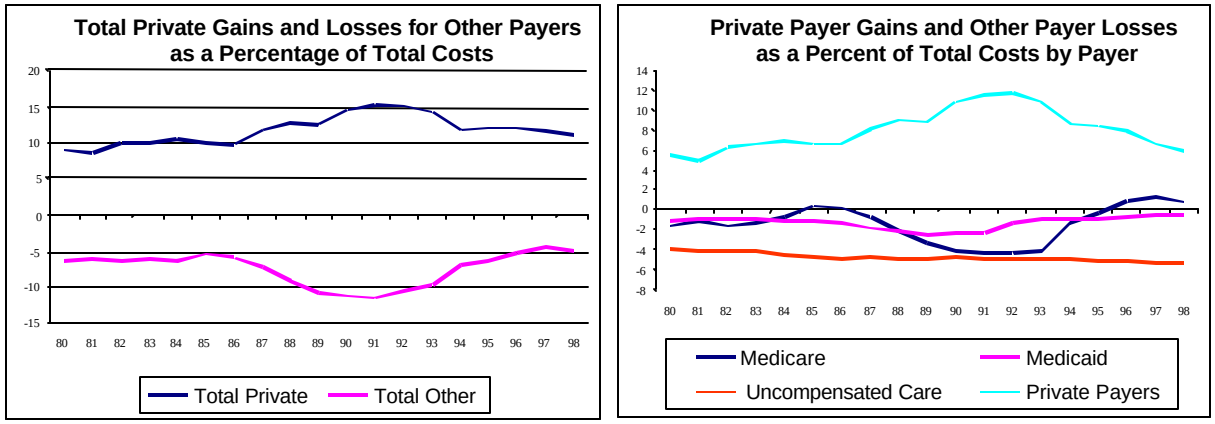
[20] Zuckerman, Stephen, "Commercial Insurers and All-Payer Regulation," Journal of Health Economics, Vol. 6. No. 2 (September 1987); and Hadley, Jack and Feder, Judy, "Hospital Cost Shifting and Care for the Uninsured." Health Affairs, Vol. 4 No. 3 (Fall 1985).

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

own analysis of hospital data indicated that about 40 percent of the change in payment shortfalls in the years studied were passed on to private payers in the form of the cost shift.[22]

Historical data show that private payer costs increase as payment shortfalls rise and decline as payment shortfalls decrease. For example, when Medicare losses (i.e., revenues minus costs) as a percent of total costs increased prior to 1995, private payer gains as a percentage of total costs increased (***Figure 45***).

Figure 45
Aggregate Losses or Gains as a Percent of Total Hospital Costs for Medicare, Medicaid, and Uncompensated Care, 1980-1998 a/ b/



a/ Private gains include private payer gains (i.e., revenues minus costs) as a percentage of total costs. Private payers include employer-sponsored coverage and individually purchased non-group coverage.
b/ Other payer losses include losses (i.e., revenues minus costs) for Medicare, Medicaid, and uncompensated care as a percentage of total costs.
Source: Lewin Group analysis of data from the American Hospital Association (AHA) survey of hospitals.

This symmetrical relationship between revenues for public and private programs suggests a substantial degree of cost shifting. Moreover, it suggests that increases in public program payments can result in lower costs for private payers. Therefore, the increase in Medicaid reimbursement rates recently passed by the Vermont legislature should help slow the growth in private health plan costs over the next few years. (The Vermont legislature recently adopted legislation that would increase VHAP payment rates to Medicare levels, although funds have not yet been appropriated for this purpose).

2. Hospital Cost Shifting

We estimated the amount of hospital cost shifting based upon the budgeted amounts for hospital spending in 2001 negotiated by BISHCA with Vermont hospitals. These budgeted amounts are based upon historical data on revenues and expenses for all Vermont hospitals and are updated to

[22] Sheils J., Gary Claxton, "Potential cost shifting under proposed Funding reductions for Medicare and Medicaid: The Budget Reconciliation Act of 1995," (Report to the National Coalition on Health Care), the Lewin Group, December 6, 1995

reflect negotiated increases in spending for current year operations. Total operating revenues from all payers are projected to be $856.9 million in 2001 (***Figure 46***). Total operating expenses are projected to be $832.8 million resulting in a net operating surplus of $24.1 million.

Figure 46
Derivation of Hospital Operating Surplus (Deficit) by Payer: Budgeted 2001
(in thousands)

	Gross Revenues	Net Patient Revenues	Operating Revenue [b/]	Operating Expenses [c/]	Operating Surplus (Deficit) [d/]	Payment to Cost Ratio
Total	**$1,301,109**	**$837,560**	**$856,927**	**$832,784**	**$24,143**	**1.03**
Medicaid	$131,820	$85,362 [a/]	**$87,324**	$105,227	**($17,903)**	**0.83**
Medicare	$460,766	$261,747	**$268,605**	$286,698	**($18,093)**	**0.94**
Commercial	$655,481	$490,451	**$500,208**	$407,854	**$92,354**	**1.23**
Free Care	$18,570	$0	**$276**	$11,556	**($11,280)**	**N/A**
Bad Debt	$34,472	$0	**$514**	$21,449	**($20,935)**	**N/A**

a/ Includes projected Medicaid payments ($60,492) plus disproportionate share hospital payments ($24,970).
b/ Includes net patient revenues plus a pro-rata share (based on percentage of gross revenues by payer) of other operating revenue.
c/ All operating expenses except provider tax payments are distributed across payers based upon the distribution of gross revenues by payer. The full amount of provider tax payments is counted as a Medicaid expense.
d/ Equals operating revenues minus operating expenses.
Source: Lewin Group estimates.

However, only commercial payers will pay more than costs. Total operating revenues from commercial payers will be $500.2 million, which exceeds projected expenses for this population ($407.9 million) by $92.3 million. This surplus will be largely offset by operating losses under Medicaid and Medicare, and bad debt and charity care expenses.

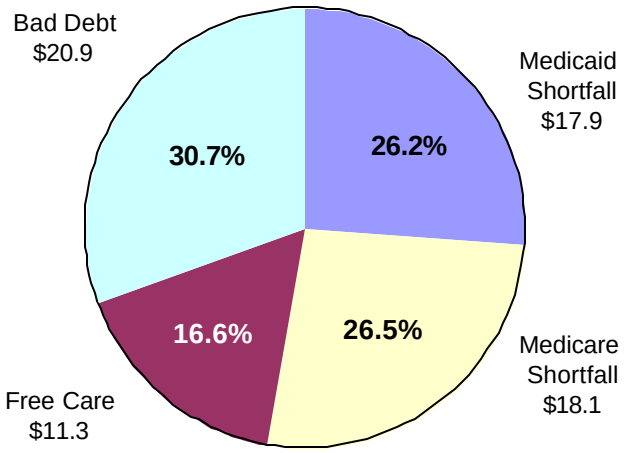
For example, expenses for Medicaid patients would be 105.2 million, which would be about $17.9 million greater than Medicaid revenues ($87.3 million).[23] Thus, Medicaid payments are equal to about 83 percent of costs. The shortfall in hospital reimbursement under Medicare would be about $18.1 million. This is the amount by which total operating revenues for Medicare patients ($268.6 million) will be less than total expenses for this population ($286.7 million). Medicare payments in Vermont are equal to about 94 percent of costs. In addition, there will be about $11.3 million in charity care and about $21.4 million in bad debt.

Payments in excess of costs for commercially insured people would be $92.3 million in 2001. Of this, $68.2 million will go to offset underpayments by other payers. Thus, the total amount of costs shifted to private payers in 2001 would be $68.2 million. The remaining $24.1 Million would comprise the hospital surplus (i.e., profit, hospital margin etc.) for that year.

[23] Medicaid Disproportionate Share Hospital (DSH) payments to hospitals ($24.9) are counted as Medicaid revenues while the hospital provider tax payments used to pay for the DSH program ($23.7) are counted as Medicaid expenses.

As shown in ***Figure 47***, the 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 47
Hospital Cost Shift by Source of Shortfall in 2001 (in millions)



Total Hospital Cost Shift = $68.2 million

Source: Lewin Group estimates.

Hospital cost shifting in Vermont appears to be proportionally greater that in the rest of the country. The ratio of private payments to costs in Vermont in 1999 was 1.22, which means that commercial payers are paying about 22 percent in excess of costs for privately insured people (***Figure 48***). By comparison, the average private payment-to-cost ratio nationwide is only 1.12 nationwide, and an average of 1.03 across New England states.

Figure 48
Hospital Private Payment-to-Cost Ratios, 1999

State	Private Payment-to-Cost Ratio
Vermont	1.22
New England	1.03
United States	1.12

Source: Medicare Payment Advisory Commission (MedPAC), 2001.

3. Physicians and Other Providers

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.[24] 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.

Medicaid/VHAP/Dr. Dynasaur physician payment rates in Vermont are equal to about 69 percent of Medicare payment rates for the state (***Figure 49***). 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 49
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 (***Figure 49***).

4. Consequences of Cost Shifting

The consequences of cost shifting differ among health care sectors, depending on regulatory and competitive forces. Hospitals have some capacity to raise their charges to selected payers to offset inadequate reimbursement by others. Among other effects, this response raises charges to

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

health insurers, self-insured employers, and uninsured individuals above what they would be in the absence of the cost shift.

Individual providers, such as physicians and dentists, are almost always reimbursed through fee schedules that are established by both public and private payers and are not subject to negotiation. The exceptions to this are very large physician practices or specialty practices upon which geographic areas are highly dependent. Because of this reimbursement system, individual providers have a minimal capacity to shift costs. For these providers, the likely consequences include financial jeopardy to practices or limitations on access to care.[25]

5. The Cost of Increasing Physician Reimbursement

The Vermont Medical Society, with the assistance of economists from the American Medical Association, has developed an estimate of how much it would cost to increase Medicaid physician reimbursement to Medicare levels. Data for this analysis was supplied by the Office of Vermont Health Access (OVHA).

While there are some issues related to data availability, the re-pricing methodology used was optimal. Physician reimbursement is based on a system called Current Procedural Terminology (CPT). Under the CPT system, each different medical service has a unique identification number. Under most reimbursement systems, including both Medicare and Medicaid, each CPT code has a specific reimbursement associated with it (although this may occasionally vary by physician specialty or type of patient). Thus, it is a straightforward process to calculate for each CPT code how much was received from Medicaid and how much would have been received if Medicaid used Medicare reimbursement.

The difficulty arises because during the period for which the data was available, the two managed care plans were responsible for a significant proportion of the care received by Medicaid beneficiaries. Information on services provided through managed care arrangements was not available.

For all services included in the analysis, to obtain equal reimbursement an additional $3.56 million (or 26.85 percent) would be necessary (***Figure 50***). OVHA applied this percentage to its projected FY02 physician claims after removing "crossover" claims. Crossover claims are those for services provided to individuals with both Medicare and Medicaid coverage. These claims are already paid at Medicare levels. OVHA estimates that $11 million will be necessary to bring its payments to Medicare levels.

[25] *Staff Report to the Joint Fiscal Committee on the Medicaid Cost Shift in Vermont***,** Prepared pursuant to Act 152, §117b, 2000 session adjourned

Figure 50
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 copay and other insurance payments.
Source: Office of Vermont Health Access (OVHA)

Using calendar 2000 claims payments, JFO estimates that an additional $12.7 million would be necessary to bring Medicaid reimbursement to Medicare levels. The difference between the OVHA and JFO estimates arise from how claims missing from the VMS/AMA analysis were estimated.

One minor question in this analysis is how age-specific fees were evaluated. For some services, Medicaid pays a higher rate for children than it does for adults. This factor needs further evaluation, but should have a minimal effect on the final estimate[26].

6. The Effect of Provider Payment Increases

A central question in the cost shift is whether increases in provider reimbursement under Medicaid/VHAP/Dr. Dynasaur would translate into savings for commercially insured people. As discussed above, the available research indicates that increases in provider reimbursement under public programs are associated with reduced cost shifting. This usually takes the form of a slower rate of increase in private payer payment levels.

However, the impact that this will have on private payer costs is limited by the fact that Medicaid/VHAP/Dr. Dynasaur accounts for only a portion of the cost shift. For example, as discussed above (***Figure 47*** above), Medicaid/VHAP/Dr. Dynasaur payment shortfalls account for only about 26 percent of the cost shift for hospitals. Even if the state were to eliminate these payment shortfalls entirely (i.e., $17.9 million), it would reduce private payer hospital payments for hospital services by only about 3.6 percent. The effect would be similar for physicians and other providers.

However, even these estimates may be high. The reason for this is that they assume providers pass-through the full amount of the increase in Medicaid/VHAP/Dr. Dynasaur reimbursement to private payers in the form of lower charges. In fact, as discussed above, providers are likely to retain a substantial portion of these payment increases either for capital improvements or increased provider income. Thus, the impact of increasing provider reimbursement levels on private payers is likely to be small. However, increasing reimbursement levels may improve provider capacity, improve access to health care or at least slow the erosion of that access.

G. Provider Capacity

One of the most important issues in this analysis is determining whether providers in Vermont would have the capacity to meet consumer demand once universal coverage is achieved. In 1980, The Graduate Medical Education National Advisory Commission (GMENAC) made recommendations for physician need for the entire population. When updated for primary care and selected specialties in 1990, there was little change to the original recommendations. Vermont has used the 1990 primary care recommendations to assess primary care provider capacity and the need for program development and found them to be fairly consistent with local perceptions and experience.

If the recommendations made by GMENAC in 1980 are still appropriate 20 years later, the current supply of physician providers is probably marginal to adequate for most areas of Vermont to accommodate the increased number of people who would seek health care. Temporal changes since 1980 would suggest that, if anything, these estimates might be somewhat low for

[26] Staff Report to the Joint Fiscal Committee on the Medicaid Cost Shift in Vermont Prepared pursuant to Act 152, §117b, 2000 session adjourned

2001. These changes include the increased proportion of elders in the population, an increase in the number of treatment options available, and higher demand (utilization) for health care.

The purpose of this section is to review the methods used to estimate the supply and distribution of health care providers in Vermont, document the supply and distribution, estimate the potential impact of universal coverage and identify health professional shortage areas and safety net providers. This section also presents estimates of the increase in health services utilization and expenditures in Vermont that would occur if all individuals were to become insured.

1. Estimating Physician and Dentist Supply in Vermont

The Vermont Department of Health, in cooperation with the Vermont Board of Medical Practice, conducts a bi-annual survey of all Vermont licensed physicians in order to determine physician to population ratios and help guide public health policy for the state. The bi-annual survey includes physicians who renewed their license as of December of the survey year; currently data is available for 1992, 1994, 1996 and 1998. Data for 2000 will be available early next year. The surveys that are returned are compared against a list of all physicians who were re-licensed. Follow-up mailings and phone calls are then made to Vermont licensed physicians, who did not return a survey to determine if they are seeing patients in Vermont, and if so, to complete the survey.

Similar bi-annual surveys are conducted in cooperation with the appropriate Licensing Boards for Doctors of Osteopathy, Dentists, Advanced Practice Nurses and Physician Assistants. Survey forms are sent to all providers licensed by one of these Boards as of the date. Follow-up telephone interviews are conducted, as needed.

Included in the survey reports are providers who deliver direct patient care services in Vermont. A substantial number of health care providers maintain Vermont licenses even though they do not practice in Vermont. These providers are excluded from all reports. Federally employed physicians who do not provide patient care outside a federal facility are not required to maintain a Vermont license, and are therefore not included, unless they do have a Vermont license. Physicians and dentists participating in residency programs are not required to maintain a Vermont license, although some choose to do so. Because all residents, clinical fellows and research fellows are practicing in a "student" capacity and are here for only a short period of time, they are excluded from the survey reports.

Participation by health care providers achieves or approaches 100 percent for all specialties. Responses over the years have been remarkably consistent supporting the validity of the results. Overall the surveys conducted by the Vermont Department of Health provide an accurate snapshot of Vermont's health care provider supply. Current census or inter-censal population estimates are used to calculate provider to population ratios.

2. Physician to Population Ratios in Vermont

Vermont as a whole falls well within the guidance provided by GMENAC for the number of physicians and primary care physicians needed to serve the population. The number of general surgeons in Vermont is below the recommendation. As can be seen in ***Figure 51*** the distribution

of physicians is quite variable by health care area (Health Care Areas are based on hospitalization for conditions appropriately treated in community hospitals). Universal access to health care, which is predicted to increase overall utilization by about 3.7 percent, can be expected to have the greatest impact on primary care providers and dentists, with somewhat lesser impact, at least in the short-term on general surgeons and specialty providers.

a. Primary Care Physicians

As seen in ***Figure 51***, Vermont's total supply and distribution of primary care providers is probably adequate to provide services to the additional people who would seek care if universal insurance were available. The supply of specialists as a whole is adequate. Potential problem areas are general surgery where Vermont appears to have a serious shortage; and for primary care in at least the four health care areas with fewer than 70 physicians per 100,000 population.

Figure 51
Vermont Physician Supply per 100,000 People — 1998

	Total	Primary Care	General Surgeons	Specialist (including General Surgeons)	Midlevel to Physician Ratio
GMENAC	148-185	70-90	11	78-95	0.50
Vermont	186	76	6	110	0.40
Brattleboro	127	79	13	48	0.55
Central Vermont	118	62	2	56	0.35
Copley	91	75	4	16	0.32
Fletcher Allen	367	87	12	280	0.40
Gifford	85	72	9	13	0.30
North Country	74	58	0	16	0.54
Northeast	89	70	11	19	0.54
Northwest	82	58	7	24	0.26
Porter	130	110	8	20	0.18
Rutland	125	66	2	59	0.23
Southwest	129	76	7	53	0.57
Springfield	106	87	10	19	0.44
Upper Connecticut Valley	108	79	3	29	0.23

Source: 1998 Survey Report: Health Care Professional Profiles. Vermont Department of Health, 2000

Another concern is the availability of primary care providers to serve the adult population, the largest group of uninsured Vermonters. As shown in ***Figure 52,*** the total number of physicians in Family Practice and Internal Medicine, and in OB/GYN are at the bottom of the range suggested by GMENAC suggesting marginal capacity to add new patients. Further, the GMENAC recommendations assume one-third of care is provided by mid-level providers, yet only four of 13 health care areas have achieved the "standard" ratio in Vermont. Finally, according to the 1998 Survey of physicians, 13 percent of primary care practices statewide were closed to any new patients and 19 percent were closed to new Medicaid and/or Medicare patients.

Figure 52
Vermont Primary Care Providers per 100,000 People — 1998

	Family Practice	Internal Medicine	Total FP and IM	Pediatrics	OB/GYN
GMENAC	28-36	25-30	53-66	7-15	8-10
Vermont	32	22	54	14	8

Source: 1998 Survey Report: Health Care Professional Profiles. Vermont Department of Health, 2000

Estimates of primary care physician requirements, provided by GMENAC are supported by other studies. GMENAC shows a need for an average of 80 primary care physicians (Family Practice, General Internal Medicine, Pediatrics, Obstetrics/Gynecology) per 100,000 population is needed to meet the medical needs of the population (range 70 to 90 per 100,000). The physician requirements are derived from a medical need model. This modeling approach identifies a requirement for physicians consistent with providing ideal levels and types of medical care to meet the needs of the population without regard to the typical barriers posed by ability to pay, access, availability etc. It does not consider the demand for care.[27]

In 1990 the GMENAC standards were re-examined through research sponsored by the Bureau of Health Professions (BHPr) in support of activities of the Council on Graduate Medical Education (COGME). This re-examination concurred with the original supply recommendations made in 1980 and projected needs through 2010.[28] In both years, the physician recommendations assumed that approximately one-third of primary care would be provided by advanced practice nurses or physician assistants. Recommendations by type of primary care provider are also included.[29]

Published reports of staffing ratio's of Health Maintenance Organizations provide further support for this level. Target ratios of physician requirements, made by staff and group model health maintenance organizations range between 1,500 and 2,000 members per primary care physician, not including OB/GYN, with a mean and median of 1,713 and 1,800 respectively (A population to physician ratio of 1500:1 is equivalent to a physician to population ratio of 67 per 100,000). These ratios account for use of Physician Assistants and Nurse Practitioners. Staffing patterns in HMOs have been used as a yardstick for national clinical workforce requirements. HMOs can provide accurate data on both staffing and the populations they serve, are staffed to provide comprehensive care to all of their members, and use an efficient mix of generalists and specialists.[30] As a result, these are representative ratios of needed staffing patterns in a primary care service setting.

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[27] (U.S.) Graduate Medical Education National Advisory Committee (April 1981). Report of the Graduate Medical Education National Advisory Committee to the Secretary, Department of Health and Human Services; Washington DC

[28] ABT Associates (April 1991). Reexamination of the Adequacy of Physician Supply Made in 1980 by the Graduate Medical Advisory Committee (GMENAC) for Selected Specialties

[29] BHPr/DHPA/DSB. (November 1980). Report on Development of Criteria for Designation of Health Manpower Shortage Areas; Report No. 78-03.

[30] T.H. Dial, S.E. Palsbo, C. Bergstein, J.R. Gabel, and J. Weiner, "Clinical Staffing in Staff-and-Group Model HMOs," *Health Affairs, Summer (1995);* 168-180

In 1996, COGME reviewed five studies undertaken to determine projections for physician to population requirements. The review included the GMENAC study which represented a need-based methodology and four studies representing demand-based models. COGME placed special emphasis on the demand-based models based upon the assumption that the health care system would be increasingly dominated by managed care arrangements. The requirements extrapolated from the five studies range from 1,695-1,299 population per primary care physician for the year 2000 and 1,333-1,235 population per primary care physician for the year 2020.[31]

b. Dentists

Vermont is not well situated to meet the projected 4.3 percent increase in utilization of dental services with universal coverage. There are no data comparable to GMENAC for dentist supply. The estimate of the current average nationwide is 1,700 patients per dentist. Statewide, Vermont has 39 primary care dentists per 100,000 population. ***Figure 53*** shows the dentist to population ratio for Vermont Counties. In addition Vermont has an aging dentist workforce with 25 percent of dentists over the age of 55 and 62 percent over age 45. Sixteen percent of general dentistry practices were closed to new patients in 1998 and 48 percent were closed to new patients enrolled in the Medicaid program.

Figure 53
Vermont Dentists by County: 1998

	Dentist per 100,000	Percentage Over age 55
Vermont	39	25%
Addison	25	60%
Bennington	45	20%
Caledonia	46	35%
Chittenden	45	13%
Essex	16	0%
Franklin	24	8%
Grand Isle	14	0%
Lamoille	53	20%
Orange	27	33%
Orleans	20	50%
Rutland	42	36%
Washington	46	26%
Windham	46	42%
Windsor	34	25%

Source: 1998 Survey Report: Health Care Professional Profiles. Vermont Department of Health, 2000

[31] Council on Graduate Medical Education. Eight Report; *Patient Care, Physician Supply and Requirements; Testing COGME Recommendations.*, Rockville, Maryland; DHHS, November 1996.

3. Comparison of Vermont to Other Jurisdictions

A database similar to the one used to calculate Vermont provider to population ratios is not available for New England and the U.S. Thus, for cross-state comparisons, Lewin used the 2001 Area Resource File. This database includes all physicians and dentists that hold current licenses. It is probably less reliable for Vermont, which is believed to have a higher per capita number of licensed physicians who do not see patients than most other states because:

? It is the only state with less than 1 million people with a medical school. This means a high number of physicians who see no patients because they are employed as teachers, administrators and researchers. Many who do see patients, have office hours less than one day per week.

? Another impact of the teaching programs, at both FAHC and at Dartmouth, is that many residents choose to become licensed during their residency while they are working under the direction of a physician. They are then included in a count of licensed physicians.

? Residents and other physicians are quite likely to maintain their Vermont license when they leave to practice in other locales. It is relatively inexpensive and makes a move back to Vermont to practice at any time much easier.

The data shown in ***Figure 54*** indicates that Vermont may be at least as likely to accommodate additional people in our health care system as other states in New England and the U.S. as a whole. This of course assumes that the ratio of patient care to non-patient care physicians is not significantly different in the other jurisdictions.

Figure 54
Physician and Dentist Supply in Vermont, New England, and the United States – 1999 [a/]

State	Patient Care Physicians per 100,000	Primary Care Physicians per 100,000	Dentists per 100,000
Vermont	186	76	39
New England	215	74	45
United States	152	56	37

a/ The number of physicians and dentists in New England and the U.S. was estimated using the AMA Physician Data which is calibrated to match physician counts developed by the Vermont Department of Health
Source: Lewin Group analysis of the 2001 Area Resource File.

4. Health Professional Shortage Areas

Though Lewin's analysis of physician supply indicates that there is probably an adequate number of physicians in Vermont, these physicians are poorly distributed across the state. The large proportion of rural areas in Vermont contribute to the mal-distribution of these physicians in Vermont, mainly because physician practice groups are less likely to practice in rural areas. ***Figure 55*** shows the location of the health professional shortage areas (HPSAs) in Vermont

designated to date by the Bureau of Primary Health Care. There are seven primary care HPSAs; two mental health HPSAs and three dental HPSAs. Recent analysis of State Primary Care service areas has identified one additional area that will qualify as a Primary Care HPSA. Work is underway to identify additional dental areas.

The Bureau of Primary Health Care (BPHC), Division of Shortage Designation is charged with designating underserved areas in the United States. As such, their focus is on identifying areas to receive additional resources, not to recommend staffing levels. The criteria they use is based upon 1974 Bureau of Census estimates of population and data on the number of non-Federal primary care physicians active in patient care in 1974. There have been no updates since. At the time, they found that the mean population ratio in the U.S. was 2,360:1 (42/100,000). The value of 3,500:1 was chosen to indicate shortage because:

1. The value was approximately 1.5 times the mean value for the nation and picked out the lowest quarter of the country's counties.

2. It was assumed that an area with a ratio of 50% worse than the national county average would not be providing adequate care.

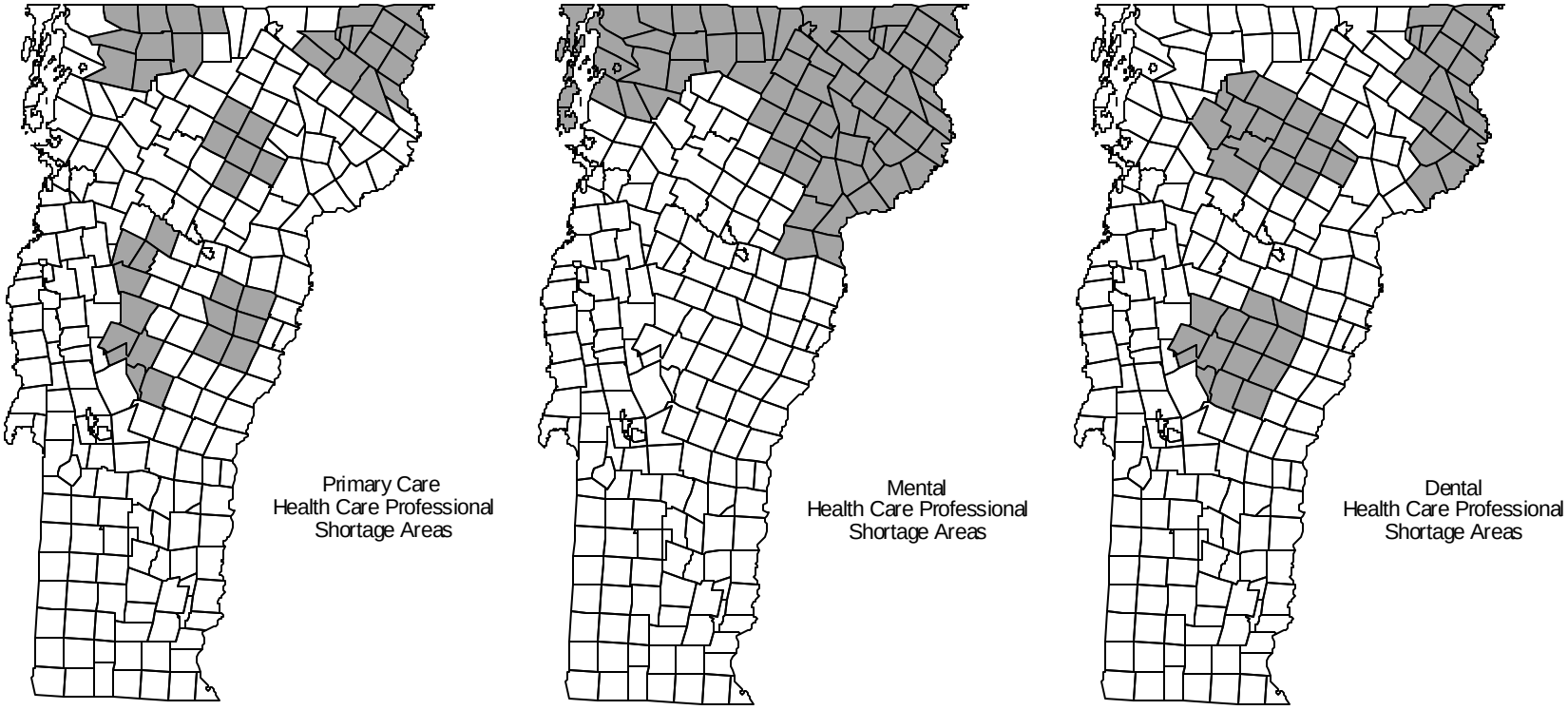
Similar methodology is used to identify areas with a shortage of dental and mental health providers. For a Dental Health Professional Area designation, the population to dentist ration must be 5000:1 or worse. For mental health, the ratio of population to mental health providers must be a) a population- to- core mental health professional ratio greater than or equal to 4,500:1 and a population-to-psychiatrist ratio greater than or equal to 15,000:1; or b) a population-to-core professional ratio greater than or equal to 6,000:1; or c) a population-to-psychiatrist ratio greater than or equal to 20,000:1.

5. Safety Net Providers

Safety net providers in Vermont include two Federally Qualified Health Centers (5 clinic sites), 21 Rural Health Clinics, nine Clinics for the Uninsured (Free Clinics) and more than 45 hospital-owned satellite practices (***Figure 56***). In addition, according to Vermont Department of Health's 1998 survey of physicians, over eighty percent of all private practice physicians in the state accept new patients on Medicaid and/or Medicare, despite their complaints about the reimbursement levels.

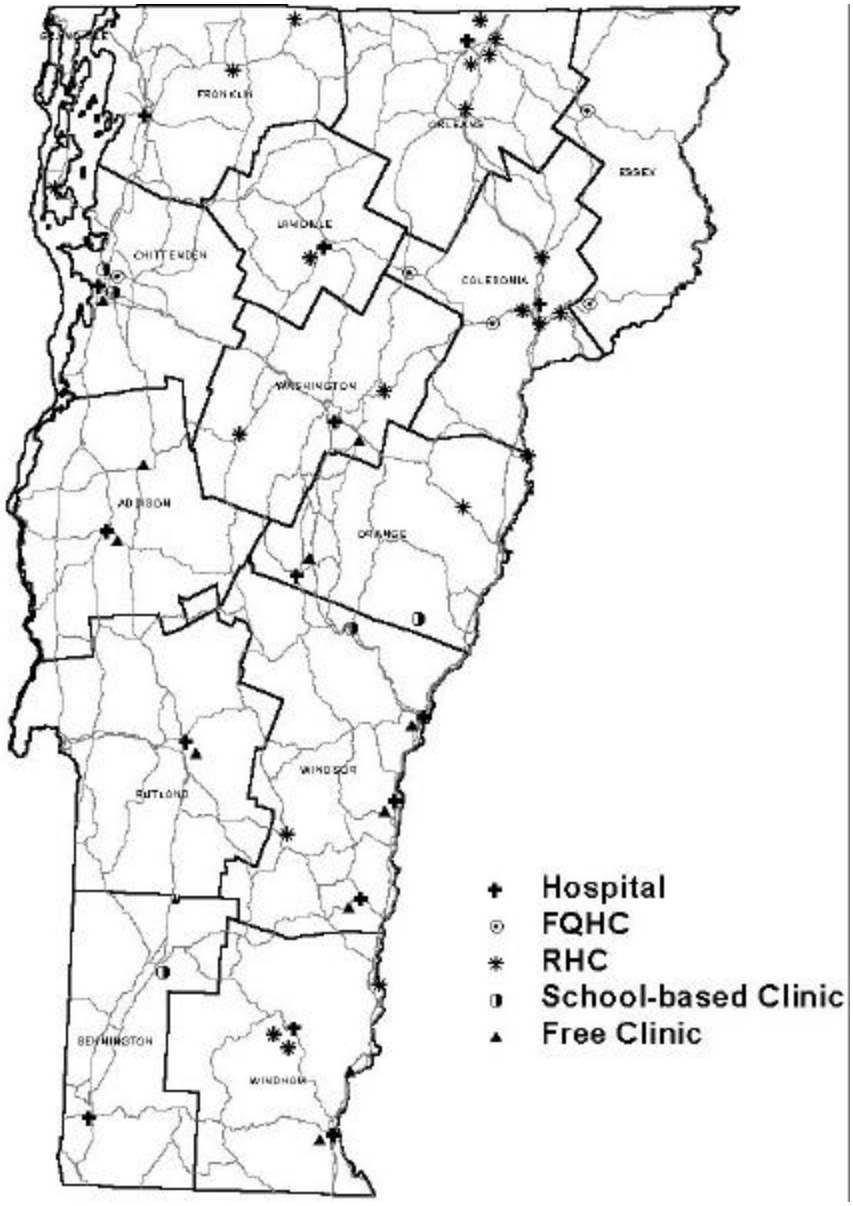
Safety net providers were represented on the HRSA steering committee. Because all serve the uninsured or underinsured now with little restriction, expansion of insurance coverage would generally enhance their revenue. The primary exception would be if there were significant expansion of public programs in the practices that do not receive cost-based reimbursement from Medicaid and Medicare. Substitution of full pay clients with lower pay public programs would be detrimental.

Figure 55
Health Professional Shortage Areas (HPSAs) in Vermont



Source: Office of Rural Health and Primary Care, Vermont Department of Health, October 2001

Figure 56
Primary Care Sites in Vermont



Source: Office of Rural Health and Primary Care, Vermont Department of Health, October 2001

6. Vermont Hospital Capacity

In addition to provider capacity, it is equally important to assess whether hospitals in Vermont would also have the capacity to meet consumer demands once universal coverage is achieved. ***Figure 57*** shows that Vermont (283) has a higher rate of beds per 100,000 than New England (255), but a slightly lower rate than the United States (311). Vermont hospitals, responding to changes in hospital utilization have significantly reduced the number of beds for which they maintain staff over the years.

Figure 57
Beds per 100,000: 1998

State/Region	Beds per 100,000
Vermont	283
New England	255
United States	311

Source: Lewin Group analysis of American Hospital Association (AHA), *Hospital Statistics 2000* data and 1998 U.S. Census Bureau data.

7. Utilization of Health Care Services

This section presents estimates of the utilization increase in health care services with universal coverage and the costs associated with these increases. These estimates are adjusted for age, sex, and health status to account for differences among the insured and uninsured population as well as for differences across state populations. Lewin's analysis begins with an estimate of the distribution of the insured and uninsured population by self-reported health status in ***Figure 58***. A slightly greater percentage of the insured report having either "excellent" or "very good health" status, and a slightly greater percentage of the uninsured report having either "fair" or "poor" health status. Nationally, almost 40 percent of the insured population report having "excellent" health status compared to approximately 36 percent of the uninsured population.

Figure 58
Distribution of Insured and Uninsured People by Self-Reported Health Status: United States

Self-Reported Health Status	Insured	Uninsured	Insured Adjusted for Age and Sex
Excellent	39.7%	35.7%	40.3%
Very Good	31.4%	27.1%	31.8%
Good	20.4%	25.7%	20.1%
Fair	6.2%	8.8%	5.7%
Poor	2.3%	2.7%	2.1%

Source: Lewin Group estimates based on the 1996 Medical Expenditures Panel Survey (MEPS) data.

The insured are typically older than the uninsured. Because health status tends to decline with age, a comparison of insured to uninsured people understates the difference in health status for the two groups. Thus, we adjusted the health status for age differences to estimate an "age and sex adjusted" health status distribution for the insured. Doing so shows an even larger gap between the health status of insured and uninsured people (***Figure 58***).

Figure 59 presents estimates of the increase in utilization of health care services if the uninsured become fully insured under universal coverage. These estimates show that the currently insured population utilizes health care services at a higher rate than the uninsured population, with the

exception of emergency room visits. However, utilization for the uninsured increases dramatically once they become insured, with the exception of emergency room visits, which actually decrease from 204 to 182 visits per 1,000.

Figure 59
Health Services Utilization for People Under Age 65 by Insured Status [a/]

		Uninsured Under Current Policy		
	Currently Insured	Current Utilization	Utilization if Become Covered [b/]	Utilization if Health Status Improves [c/]
Physician Visits per 1,000	3,650	1,705	3,432	3,513
Dental Visits per 1,000	1,222	565	1,166	1,159
Hospital Stays per 1,000	79	68	77	77
Outpatient Visits per 1,000	484	305	482	494
Emergency Room Visits per 1,000	188	204	182	187

a/ Utilization rates per 1,000 people.
b/ Assumes that health services utilization for newly covered people adjusts to the levels reported by insured people with similar age, sex, and health status characteristics.
c/ Assumes that health status of newly covered people adjusts to levels reported by insured people by age and sex.
Source: Lewin Group analysis of the 1996 Medical Expenditures Panel Survey (MEPS) data.

If we also assume that health status improves when the uninsured become insured, utilization of physician services, outpatient visits, and emergency room visits actually increase slightly. Hospital stays remain the same after adjusting for health status and dental visits actually decrease slightly.

8. Costs of Covering the Uninsured

Figure 60 presents estimates of the percentage increase in aggregate statewide utilization of health care services (i.e., utilization for both insured and uninsured) if the uninsured become covered. These estimates indicate that utilization of health care services would increase if the uninsured become covered, with the exception of emergency room visits, which actually decrease by 0.9 percent. The most significant increase was for physician and dental visits, 3.7 percent and 4.3 percent respectively.

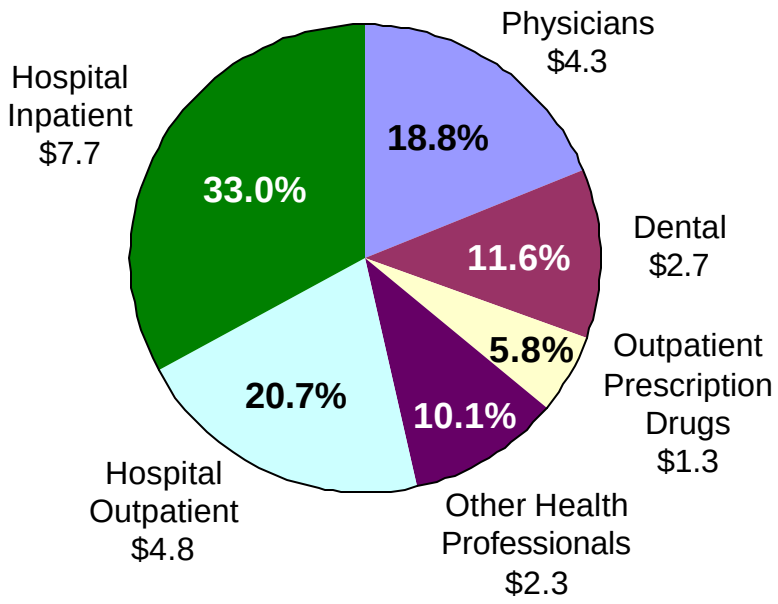
Figure 60
Percentage Increase in Aggregate State-Wide Utilization of Health Care Services if Uninsured Become Covered

	Percentage Increase in Utilization
Physician Visits	3.7%
Dental Visits	4.3%
Hospital Stays	0.7%
Outpatient Visits	2.6%
Emergency Room Visits	(0.9%)

Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM)

Figure 61 presents estimates of the increase in health services costs if universal coverage is achieved in 2002. Hospital inpatient services, which account for the largest percentage of costs (33.0 percent), are estimated to increase by $7.7 million in 2002. The smallest estimated increase in costs is for outpatient prescription drugs ($1.3 million). Overall, health care costs are estimated to increase by $23.1 million if universal coverage is achieved in 2002.

Figure 61
Increase in Health Services Costs if Universal Coverage is Achieved in 2002 for Vermont (in millions)



Total Increase = $27.6 million

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

SECTION FOUR: OPTIONS FOR EXPANDING COVERAGE

One of the primary objectives of the State Planning Grant was to evaluate the cost and coverage impacts of a wide range of options for expanding insurance coverage in Vermont. During the course of the project, Lewin analyzed several general approaches for increasing coverage. These include mechanisms for expanding coverage through public programs and through private insurance.

For each option, Lewin estimated the number of people who would become insured and the cost of subsidies provided under the program. This includes estimates of the cost to the state and costs to the federal government under policies where federal matching funds are available. Also within each of the eight general types of policy options, Lewin examined several variants to show the sensitivity of program costs and coverage impacts to various design parameters.

The purpose of this section is to introduce these policy options and present estimates of their impacts. It also provides a description of the methods and approaches used to perform these analyses. The Lewin presentations on coverage options are presented in ***Appendix H***. A detailed analysis of adopting a single-payer model for Vermont is presented in ***Appendix F***. The analysis is presented in the following sections:

? Methods and Approach;

? Increase Participation Among VHAP-Eligible People;

? Expanding Medicaid Eligibility for Adults;

? Medicaid Buy-In to Employer Coverage for Children;

? Buy-In to VHAP for Employers and Individuals;

? Programs to Assist Families in Purchasing Coverage

? Subsidies to Help Employers Purchase Coverage for Their Workers;

? Create Low-cost Health Insurance Coverage Options;

? A Single-Payer Model for Vermont;

? Comparison of Policy Alternatives; and

? Policy Recommendations of Steering Committee

A. Methods and Approach

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 HBSM is a micro-simulation model of the U.S. health care system. The model 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. The model also has been used to simulate the impact of numerous universal coverage proposals such as single-payer plans and employer mandates. For this project, Lewin adapted the model to simulate these impacts for Vermont using primarily data from the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), Vermont Division of Health Care Administration.

The primary database used in the model is the 1996 National Medical Expenditure Panel Survey (MEPS) data developed by the Agency for Healthcare Research and Quality (AHRQ).[32] These data provide information on sources of insurance coverage, health spending and demographic characteristics for a representative sample of households. Lewin adjusted these data to reflect the recent BISHCA survey of Vermont households showing the distribution of people in Vermont by source of insurance coverage and other demographic characteristics.[33] The health expenditure data in the database were also adjusted to reflect estimates of health expenditures in the state as estimated by BISHCA.[34] 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.[35]

Lewin developed HBSM to provide comparisons of the impact of alternative health reform models on health coverage and expenditures for employers, governments and households. The key to its 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 2001. Lewin also "aged" these data to be representative of the population in the base year (2001) based upon recent economic, demographic and health expenditure trends. The resulting database provides a detailed accounting of the Vermont health care system. These base-case data then serve as the reference point for Lewin's simulations of alternative health reform proposals.

Lewin estimated the impact of various health reform initiatives using a series of methodologies that apply uniformly in all policy simulations. The model first simulates how specified state policy options would affect sources of coverage, health services utilization, and health expenditures by source of payment (***Figure 62*****).** Mandatory coverage programs such as employer mandates or single-payer models can be simulated based upon the detailed employment and coverage data recorded in the database. The model also simulates enrollment in voluntary programs such as tax credits for employers and employees, based upon multivariate models of

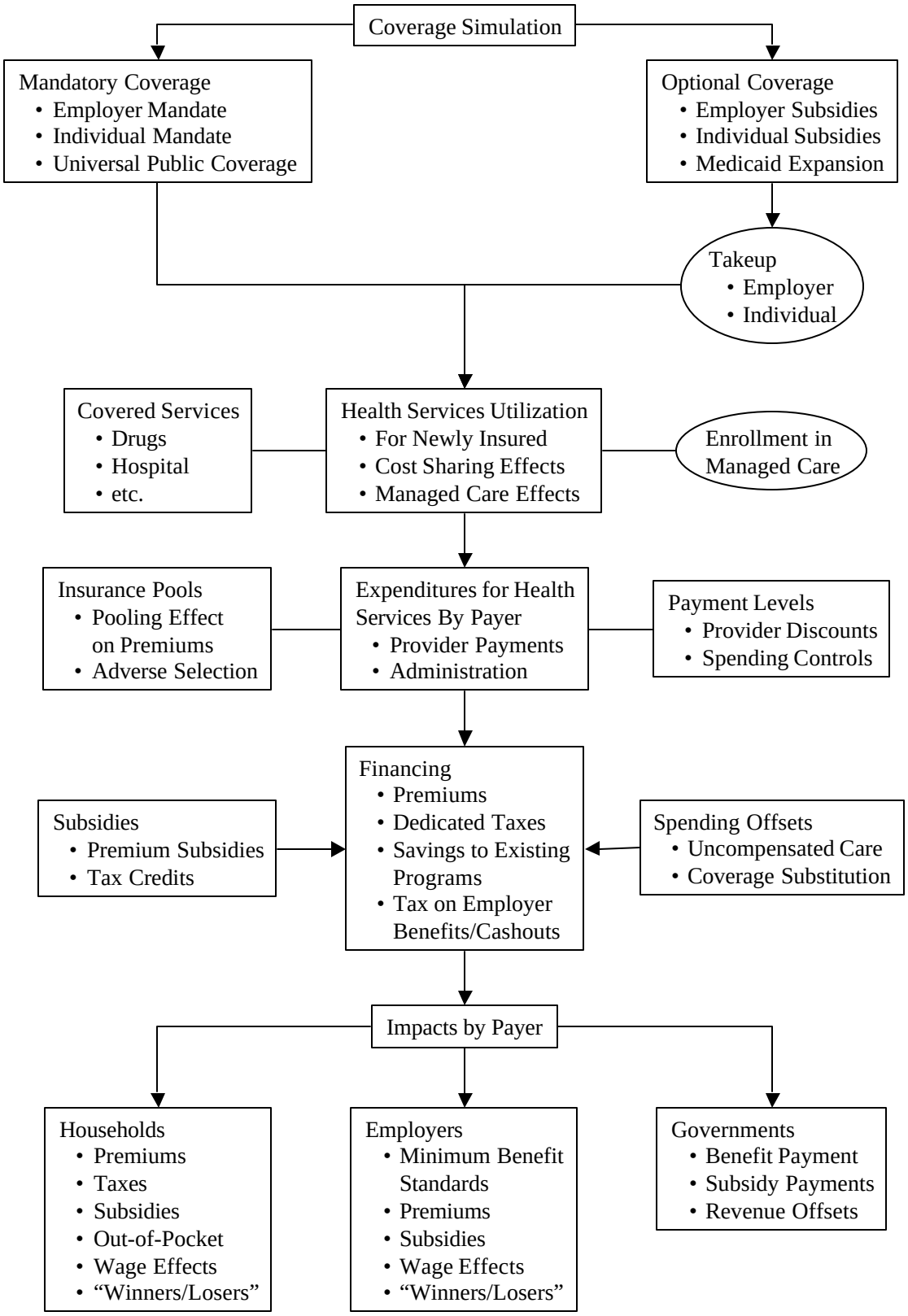
[32] MEPS is sponsored by the Agency for Health Care Policy and Research. For more information about MEPS, see J. Cohen et al. , "The Medical Expenditure Panel Survey: a national health information resource" *Inquiry*. 1996-97 Winter;33(4):373-89.

[33] "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.

[34] "Vermont Health Care Expenditures Analysis, 1999", The Department of Banking, Insurance, Securities and Health Care Administration, Vermont Division of Health Care Administration, August 2001.

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

Figure 62
Flow Diagram of the Health Benefits Simulation Model (HBSM)



how coverage levels for these groups varies with the cost of coverage (i.e., modeled as the premium minus the tax credit). 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").

The HBSM is designed to facilitate comparisons of alternative health reform initiatives using uniform data and assumptions. For example, take-up rates for Medicaid and various tax credit/premium voucher policies are simulated using uniform take-up equations and modules. Uniform methods are also used to simulate changes in health services utilization attributed to changes in coverage status and cost-sharing parameters. The model also uses a series of uniform tables for reporting the impacts of these policies on households, employers and governments. This uniform approach assures that the estimates of program impacts for very different policies are based upon consistent assumptions and reporting formats.

Once changes in sources of coverage are modeled, HBSM simulates the amount of covered health spending for each affected individual, given the covered services and cost sharing provisions of the health plan provided under the proposal. This includes simulating the increase in utilization among newly insured people and changes in utilization resulting from the cost sharing provisions of the plan. In general, Lewin assumed that utilization among newly insured people will increase to the level reported by insured people with similar characteristics.

The various steps included as part of the simulation modeling include:

? **Establishing a Baseline:** HBSM is based upon a representative sample of households, which includes information on the economic and demographic characteristics of these individuals as well as their utilization and expenditures for health care. As discussed above, these data were derived from the 1996 Medical Expenditures Panel Survey (MEPS) that is controlled to replicate the distribution of individuals by coverage status and demographic group reported in the recent survey of Vermont households. Lewin also used the Kaiser/HRET survey of employers in simulations of policy scenarios involving employers. In addition, Lewin adjusted these data to show the amount of health spending in the state by type of service and source of payment as estimated by BISHCA.

? **Determining Eligibility:** The HBSM database provides the detailed demographic and economic data required to identify people who would be eligible for public- or private-sector programs designed to expand insurance coverage. The model identifies those who meet the income or work eligibility provisions for any coverage expansion proposals modeled. Eligibility for Medicaid or other income-tested subsidy programs is determined on the basis of family income in each month. The model also identifies people who are potentially affected by programs designed to expand employer coverage such as tax credits and income-tested premium subsidy programs.

? **Modeling Program Participation:** Most of the major health reform proposals developed in recent years would rely upon providing incentives for individuals to obtain coverage rather than mandating coverage. This has required the development of models that estimate the likely response of individuals to various forms of subsidized coverage. Lewin has developed

models of enrollment for the Medicaid/SCHIP program nationally to simulate enrollment among people who become eligible for VHAP under proposed expansions in this program. Lewin has also developed multivariate models of how changes in premiums affect the decision to take-up private insurance coverage.

? **Modeling Employer Responses:** The model also simulates the impact of policies affecting the employer's decision to offer insurance and the resulting impact on employee coverage. An example of one policy option is employer tax credits designed to encourage employers to offer coverage and tax reform proposals that change the relative tax advantages of employer-provided insurance. In these simulations, the model first simulates changes in employer decisions to offer coverage at the firm level using the Kaiser/HRET data and then simulates the corresponding impact on workers who have been assigned to each of the firms in the Vermont database. As discussed above, this often involves compiling data on the workers assigned to each firm such as the average marginal tax rate for workers or the number of employees who are eligible for a particular coverage expansion program.

? **Program Costs and Health Expenditures:** The model simulates the cost of health coverage expansion proposals based upon the coverage provisions of the proposal. For tax credit proposals and premium vouchers, program costs are equal to the amounts of the credits or vouchers for people who participate in the program. Under proposals where benefits for eligible individuals are provided through a public program (e.g., Medicaid), costs are equal to the cost of the health services used by enrollees. These costs are estimated based upon the cost of covered services received by individuals in the household database who are simulated to enroll in the program. This includes expenditures reported in these data during the months in which the individual is simulated to participate in the program, plus an estimated increase in spending for newly insured individuals.

For each option, the model estimates the impact on health expenditures in Vermont by type of service (such as hospitalization and physician visits) as well as the changes in costs for various stakeholder groups. HBSM also provides information on the financial impact of programs to expand coverage for state, federal and local governments. It provides estimates of how these policies may affect employer costs by firm size and industry as well. Finally, it provides estimates of the impact of these reforms on household health spending by income, age and several other population characteristics. The model can also simulate several policy options at the same time.

B. Increase Participation Among Medicaid/VHAP/Dr. Dynasaur Eligible People

The Vermont household survey data indicates that up to 39 percent of all uninsured people in the state are actually eligible for traditional Medicaid, VHAP, or Dr. Dynasaur. The survey reports that there are 51,390 uninsured people in the state, including 6,191 children and 45,199 adults (***Figure 63)***. About 4,914 children have incomes below 300 percent of the FPL, which is the income eligibility level under the Dr. Dynasaur. In addition, there are about 15,096 adults with incomes below the VHAP income eligibility levels for adults (i.e., 185 percent of FPL for

parents and 150 percent of the FPL for non-custodial adults).[36] This is a total of 20,010 uninsured people who meet the income eligibility levels for the program. Thus, about 39 percent of the uninsured in Vermont are actually eligible but not enrolled in Medicaid/VHAP/Dr. Dynasaur.

Figure 63
People in Vermont by Age, Income as a Percentage of the Federal Poverty Level (FPL) and Coverage Status in 2000

	All Ages		All Children		All Adults	
	Total	Uninsured	Total	Uninsured	Total	Uninsured
Less than 100% FPL	79,580	11,104	19,905	1,018	59,675	10,086
100% - 149% FPL	62,696	8,280	17,319	1,150	45,377	7,130
150% - 185% FPL	50,846	7,022	20,579	1,190	30,267	5,832
186% - 225% FPL	47,357	7,354	9,098	667	38,259	6,687
225% - 300% FPL	102,544	4,118	28,237	889	74,307	3,229
300% FPL or More	265,805	13,512	52,387	1,277	213,418	12,235
Total	**608,828**	**51,390**	**147,525**	**6,191**	**461,303**	**45,199**
Percentage Uninsured		**8.4%**		**4.2%**		**9.8%**

Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

However, not all adults who meet the income eligibility requirements are eligible. This is because adults must be uninsured for at least 12 months to qualify (exceptions are permitted for people who involuntarily lose their coverage). The BISHCA survey indicates that about 31 percent of uninsured people in the state have been uninsured less than 12 months which is the length of the waiting period requirement. To account for the fact that many of these individuals would qualify for an exception to the rule it was assumed that 25 percent of income eligible adults do not meet this waiting period requirement. There is no waiting period requirement for children. Using this assumption, Lewin estimates that there are about 20,010 uninsured people in Vermont who are eligible for Medicaid/VHAP/Dr. Dynasaur coverage.

These data indicate that the state could substantially reduce the number of uninsured by increasing enrollment in the existing programs. For example, if the state could sign up about half of those who are eligible but not enrolled in the program, the number of uninsured would be reduced by about 10,000 people (***Figure 64***)**.** This would reduce the percentage of people without health insurance from its current level of 8.4 percent to 6.8 percent. The total cost of covering these people would be $29.3 million, of which the state share would be $10.6 million. This assumes that federal matching funds are available and that the increase is within the budget neutrality requirement of the 1115a waiver.

[36] Estimate reflects the impact of the 12-month waiting period.

Figure 64
Potential Impact of Increasing Medicaid/VHAP/Dr. Dynasaur Enrollment: Assumes Half of Eligible Not Enrolled Population Becomes Covered

	Number Enrolled	Reduction in Uninsured	Total Cost	State Share of Cost
Children	2,457	2,457	$2.6	$0.7
Adults	7,549	7,549	$26.7	$9.9
TOTAL	**10,006**	**10,006**	**$29.3**	**$10.6**

Source: Lewin Group estimates.

The state has already implemented a number of initiatives designed to increase enrollment of children (***Figure 65)***. These include media campaigns, outreach through schools and conferences, and presentations to health professionals and various community organizations. The state has streamlined the enrollment process by reducing the length of the application and permitting mail-in applications. Children are also certified for 12 months rather than the 6 months allowed in some other states, which is designed to keep children in the program longer. The state also conducts a number of outreach activities through schools, child-care organizations and employers.

There are other potential changes that could increase enrollment. For example, the state could eliminate the premium requirement for children living above 225 percent of the FPL. The premium for these families ranges between $10 and $25 per family per month depending upon income. The available research indicates that participation is reduced by about one-third in cases where a premium is required, even where the premium is as low as $10 per month. Thus eliminating the premium could result in a substantial increase in enrollment (premium increases are pending).

C. Expanding Medicaid Eligibility for Adults

The income eligibility levels under the Vermont VHAP program are among the highest in the country. As shown in ***Figure 66,*** 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).[37] Pregnant women are covered through 200 percent of the FPL, and all children are eligible through 300 percent of the FPL.[38]

[37] 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.

[38] 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.

Figure 65
Vermont Covering Kids Project: Overview of Outreach Activities

Public Awareness

- Media
  - "Got Insurance" Posters
  - "Got Insurance" Band-Aid Dispense Magnets
  - "Got Insurance" Newsletter Ads
  - "Got Insurance" Buttons
  - DOH Insurance Cards (all Vermont Schools)
  - Dr. Dynasaur Bookmarks
  - Governor Dean PSA
- Schools
  - School Nurses
  - Guidance Counselors
  - School Report Card Insert
  - First Day of School Activities
  - Parent Back-to-School Night
- Conference and Resource Fairs
  - VT Home Show and Health Fair
  - Dr. Dynasaur Costume

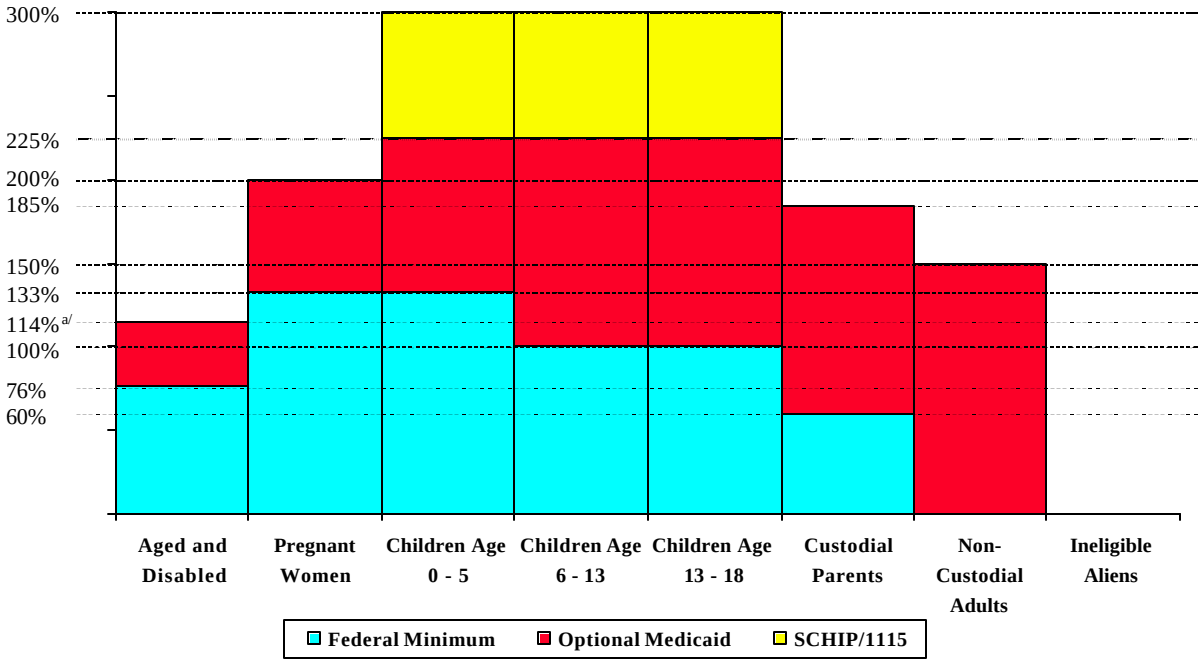
Presentations, Trainings, Information Dissemination, etc.

- Child Care Providers
- Physicians
- Hospital Emergency Staff
- Non-Profit Providers
- Health Fairs
- Landlord Associations
- Ecumenical Councils
- Youth Groups and Organizations
- Guardian Ad Litems
- Food Distribution Programs
- Parent/Child Centers
- Community Action Agencies
- Refugee Resettlement Programs
- Local Businesses (Human Resource Depts.)

"Gateways" (for screening for health insurance)

- Birth Certificates
- Child Care Providers
- Physicians (health screening incorporated into periodicity schedule)
- School Emergency Cards
- Dept. Of Employment and Training
- Hospitals (on-line application process)
- Free Clinics
- Child, Youth, and Family Support Organizations

Figure 66
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.[39] 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.[40]

Under section 1931 (b) of federal Medicaid law, Vermont has the option to increase the income eligibility level for parents through Medicaid to match the maximum income level at which children are eligible for Dr. Dynasaur (i.e., 300 percent of the FPL). Vermont could use this option to increase the income eligibility level for parents from its current level of 225 percent of the FPL to 300 percent of the FPL. For these newly eligible adults, Vermont would receive

[39] 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.

[40] 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).

federal matching funds at Vermont's standard federal Medicaid matching rate of about 63 percent.[41]

Vermont could also increase income eligibility levels for non-custodial adults, but would not receive federal matching funds. The state receives matching funds for non-custodial adults below 150 percent of the FPL now only 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 states 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. Analyses performed by the state indicate little flexibility under the budget neutrality requirement.

In this analysis, Lewin estimated the impact of expanding coverage to adults to various income levels up to 300 percent of the FPL. People between 225 percent and 300 percent of the FPL would also pay a premium on a sliding scale with income similar to that used in Dr. Dynasaur for children in this income range. Lewin estimated coverage and cost impacts under the following Medicaid expansion options:

? Cover custodial parents below 225 percent of the Federal Poverty Level (FPL);

? Cover custodial parents below 300 percent of the FPL;

? Cover non-custodial adults below 185 percent of the FPL;

? Cover non-custodial adults below 225 percent of the FPL;

? Cover non-custodial adults below 300 percent of the FPL;

Using the methods described above, Lewin estimated that about 81,900 adults would meet the income eligibility levels if eligibility were increased to 300 percent of the FPL for all adults (***Figure 67***)**.** However, most of these adults already have coverage from some other source and would not qualify due to the waiting period requirement. Based up historical data on enrollment patterns under such public programs, Lewin estimates that about 13,000 of these adults would enroll. In addition, in the course of screening adults for eligibility, Lewin estimates that about 500 children who are currently eligible but not enrolled would become covered. These include children whose parents do not pursue enrollment for their children until they are motivated to apply for themselves or as a family unit.

[41] Under Medicaid, the federal government pays about 63 percent of the program costs under the traditional Medicaid program and about 73 percent of costs under the portion of Dr. Dynasaur program attributed to the State Children's Health Insurance Program (SCHIP).

Figure 67
Estimated Coverage and Cost Impacts of Selected Expansions in the Vermont Medicaid/SCHIP Program

	Newly Eligible People (in thousands)	Newly Enrolled People (in thousands)	Newly Insured Enrollees [a/] (in thousands)	Benefits Costs (in millions)	Premium Revenues b/ (in millions)	Net Program Cost (in millions)	State Share of Costs (in millions)
Eligibility Level							
Below 185% FPL							
Children	- -	- -	- -	- -	- -	- -	**- -**
Parents	- -	- -	- -	- -	- -	- -	**- -**
Other Adults	10.4	4.5	4.3	$9.5	- -	$9.5	**$9.5**
Total	**10.4**	**4.5**	**4.3**	**$9.5**	**- -**	**$9.5**	**$9.5**
Below 225% FPL							
Children [c/]	- -	0.5	0.5	$0.3	- -	$0.3	**$0.1**
Parents	8.8	1.5	0.5	$2.8	- -	$2.8	**$1.0**
Other Adults	20.3	6.8	5.9	$14.6	- -	$14.6	**$14.6**
Total	**29.1**	**8.8**	**6.9**	**$17.7**	**- -**	**$17.7**	**$15.7**
Below 300% FPL							
Children [c/]	- -	0.5	0.5	$0.3	- -	$0.3	**$0.1**
Parents	36.0	4.4	1.2	$8.2	$3.1	$5.1	**$1.9**
Other Adults	45.9	8.6	6.6	$17.4	$2.0	$15.4	**$15.4**
Total	**81.9**	**13.5**	**8.3**	**$25.9**	**$5.1**	**$20.8**	**$17.4**

a/ The number of new enrollees who otherwise would been uninsured.
b/ Lewin assumed that a premium would be required for people above 225 percent of the FPL on a sliding scale with income.
c/ Lewin estimates that there would be a small increase in SCHIP enrollment as newly eligible parents become enrolled. These SCHIP-eligible children who have not enrolled under the current program.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

Overall, about 13,500 people would become enrolled in VHAP. Of these, 8,600 (64 percent) would be non-custodial adults. About 4,400 (32 percent) would be parents. Another 500 (4 percent) would be children who are already eligible for the program. Of the 13,500 people who would enroll, about 8,300 (61 percent) would be people who otherwise would be uninsured. The remaining 5,200 (39 percent) would be people who otherwise would have been covered under a private employer health plan.

Expanding coverage for adults to 300 percent of the FPL would cost about $20.8 million (***Figure 67*****).** This includes program costs of $25.9 million less premium revenues of about $5.1 million. This is an average cost for this population of about $128 per member per month (PMPM). Of this the state would be responsible for $17.4 million.[42] This reflects the fact that non-custodial adults would not be eligible for a federal match. ***Figure 67*** also shows estimates for Medicaid eligibility expansions to 185 percent and 225 percent of the FPL.

D. Medicaid Buy-In to Employer Coverage for Children

Under current law, states are permitted to cover Medicaid and SCHIP participants under an employer plan in instances where employer-sponsored coverage is available and cost effective. For example, the Vermont program could screen working VHAP-eligible people for the availability of employer coverage at work. The state would then compare the employee premium contribution required to enroll the family in the employer plan with the expected cost of covering the individual under VHAP. If the employer premium contribution is less than costs under VHAP, the state can pay the employee share of the premium to cover the individual under the employer's plan. This will typically occur in cases where the employer pays at least 50 percent of the premium. However, the state must provide wrap-around coverage to cover all services and cost sharing amounts covered by the VHAP program that are not covered under the employer-sponsored plan.

Several states including Vermont have utilized this approach under Medicaid. However, most states have considered it to be too expensive to administer, particularly in cases where the state must provide wrap-around coverage. These programs have typically been small due to the fact that few Medicaid beneficiaries are working and eligible for employer benefits. This approach has received more attention as income eligibility levels for children have increased to levels where there are more working families. The opportunities for this type of program are strong in Vermont because eligibility levels are sufficiently high that many families will have access to employer-sponsored coverage. The program's impact would be limited by the fact that the number of children covered under SCHIP is small (3,038 in FY02 budget).

For example, the state could screen Dr. Dynasaur-eligible children for the availability of employer-sponsored coverage at a parent's place of employment. The state would then compare the cost of coverage under the program with the employee share of the premium for family coverage under the parent's employer-sponsored plan. If this is less than the cost of coverage

[42] The federal matching rate is about 63 percent for Medicaid recipients and about 73 percent for people covered under the SCHIP program. In Vermont, the enhanced matching rate also applies to children age 6 and older between 100 percent and 133 percent of the FPL.

under Dr. Dynasaur, the state would pay the family share of the premium on the working parent's plan to cover the child under the private employer health plan.

This approach will often have the added bonus of covering the spouse of the worker as well. This would occur in instances where paying the family premium automatically extends coverage to the spouse of the worker. Thus, coverage could be extended to parents who are not eligible for the Medicaid/VHAP/Dr. Dynasaur program as long as there is no additional cost to the program.

Lewin estimated the coverage and cost impacts of adopting this approach for the Dr. Dynasaur eligible populations. These estimates are based upon a study of enrollment and costs under the Vermont Medicaid program, which has been using this approach for nearly 10 years. This study estimated the percentage of the caseload that was potentially eligible for this program and estimates of the savings resulting from this approach under the Vermont program. Based upon these data, Lewin estimates that if implemented in Vermont, about 823 children would qualify, including 355 who would not have enrolled in the absence of the program (includes children and spouses of working parents). Lewin estimates that the state would save about $110,000 under this program (***Figure 68***).

Figure 68
Estimated Impacts of a Children's Buy-In to Parent's Employer Plan

	Number Enrolled	Newly Insured	Total Program Costs (in thousands)	State Share (in thousands)
Buy in for Children under Medicaid/VHAP/Dr. Dynasaur	823	355	($391)	($101)

Source: Lewin Group estimates based upon experience in other states with program.

E. Buy-In to VHAP for Employers and Individuals

The VHAP program could be used to provide a lower cost coverage alternative for individuals and employers. For example, individuals without access to employer coverage living below 300 percent of the FPL could be permitted to purchase coverage under the VHAP program by paying a premium. Similarly, small employers 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 the same as those provided under the current VHAP program. However, buy-in participants would be required to pay a premium equal to the full cost of their coverage (i.e., average cost per enrollee).

Although participants would be required to pay the full premium for coverage, it 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 VHAP program are generally substantially lower than payments rates under private plans. As discussed above (in Section Three), payments to physicians and other providers under VHAP are currently up to 40 percent less than private

payer rates.[43] In addition, administrative costs under VHAP are generally lower than in private plans because there are no commission payments to brokers and agents, and there is no allowance for insurer profits.

The lower cost of coverage under the buy-in would make coverage substantially less costly than in the private market resulting in an increase in coverage and a reduction in the number of uninsured. For example, coverage under the VHAP program would be comparable to the coverage provided under the BCBS of Vermont "BlueCare" Point of Service option-A program, with three exceptions: 1) BlueCare does not provide short-term care coverage; 2) BlueCare requires greater co-payments for services than VHAP; and 3) there is a 50 percent copayment for drugs up to a maximum out-of-pocket payment limit of $750 (***Figure 69***). However, after adjusting for these differences, the VHAP buy-in premium would be substantially less than private coverage due to lower administrative costs and lower provider payment levels.

Figure 69
Coinsurance Under VHAP and BlueCare (BCBS) Compared

VHAP Cost Sharing	
Deductible	None
Co-Payments	Nominal
Prescription Drugs	50% co-pay with $750 Maximum Out-of-pocket limit
BlueCare Program	
Deductibles	
With referral	None
Without referral	$500
Co-payments	
Primary care	$10
Other providers (with referral)	$20
Without referral (up to limit or $3,000)	30%
Prescription Drug Co-pays	
Generics	$10
Preferred	$15
Non-Preferred	$30

Lewin estimates that the average premium for single coverage under the BlueCare Option-A product would be $329 per person per month (PMPM) in 2003 (***Figure 70***). This estimate was developed in consultation with representatives of BCBS of Vermont and BISHCA officials for 2001. Lewin projected the premium to 2003 based upon recent trends in spending. This compares with an estimated average cost of $206 PMPM under the VHAP program. About two-thirds of the difference in premiums is attributed to lower provider reimbursement levels under VHAP with lower administrative costs accounting for the remainder of the difference. This premium reduction is likely to attract many individuals and employers to the program.

[43] Legislation was adopted in the FY02 Budget Act that would increase the payment rates to Medicare levels over the next few years. However, the legislature has not yet appropriated the funds required to implement these payment increases.

Figure 70
Derivation of Monthly Premium Estimates for VHAP Buy-in in 2003

	At VHAP Payment Levels		Increase Payments on VHAP Physician/Other Professionals to Medicare Levels		With Increase in VHAP Payments for All Medical Services to Medicare Levels		Medicare Payment Levels with $100/$200 Deductible		Medicare Payment Levels with $200/$400 Deductible	
BlueCare Point of Service Option - Program A [a/]		**$329**		**$329**		**$329**		**$329**		**$329**
Estimated Administration [b/]	$57		$57		$57		$57		$57	
Pure Premium (i.e., benefits, costs)	$272		$272		$272		$272		$272	
Change in Administrative Cost		**-$44**		**-$44**		**-$44**		**-$38**		**-$38**
BC/BS Administration	$57		$57		$57		$57		$57	
VHAP Administration [c/]	$13		$13		$13		$19		$19	
Change in Pure Premium		**-$79**		**-$48**		**-$39**		**-$65**		**-$76**
BC/BS Pure Premium	$272		$272		$272		$272		$272	
Payment Level Reductions										
Hospital [d/]	-$35		-$35		-$26		-$26		-$26	
Physician/Other Providers [e/]	-$52		-$21		-$21		-$21		-$21	
Prescription Drug Rebate [f/]	-$3		-$3		-$3		-$3		-$3	
Change in Copayment Required	$11		$11		$11		-$15		-$26	
VHAP Buy-in Premium in 2001		**$206**		**$237**		**$245**		**$226**		**$216**
Administrative Cost	$13		$13		$13		$19		$19	
Pure Premium	$193		$224		$232		$207		$197	

a/ BlueCare option program A, Point of Service: $10 primary care co-pay; $20 other office visits; no inpatient or outpatient surgery deductible; prescription drug co-payments: $10 generics; $15 preferred, $30 non-preferred. Premium for 2001 is $298, which Lewin indexed to 2003

b/ Assumes that administrative costs (including marketing and brokers fees) are equal to about 17.5 percent of benefits costs for groups with 25 or fewer workers.

c/ VHAP administrative costs are equal to about 7 percent of benefits costs which comes to about $12 per month for adults currently enrolled under VHAP.

d/ Lewin estimates that hospital payments under the VHAP program are about 32 percent less than commercial payment rates and about 8 percent less than Medicare payment rates.

e/ Lewin assumed that physician payment levels are about 50 percent less than commercial payment levels based upon payment level data indicating that: Medicaid physician payment levels in Vermont are 31 percent less than Medicare payment levels; and national data indicating that Medicare physician payment levels are about 20 percent less than commercial rates. See: Stephan Norton, "Recent Trends in Medicaid Physician Fees, 1993-1998", The Urban Institute.

f/ Assumes a net savings of 10 percent under Medicaid prescription drug rebate program.

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

Under recent legislation, the state's objective is to increase payment levels to Medicare levels over the next few years. This will increase the VHAP premium, and thereby reduce the number of people who would be induced to enroll. For example, if these payment increases were to be fully implemented in 2003, the VHAP premium would increase to $245. However, the VHAP premium would continue to be less than the BlueCare Option-A premium because Medicare payment amounts are still up to 20 percent less than private payments for comparable services. The VHAP premium also could be reduced by including a small deductible. For example, the VHAP premium could be reduced to $226 PMPM by requiring a $100 deductible ($200 per family).

Enrollment would also be determined by the eligibility criteria used. For example, in the first scenario, it is assumed that eligibility would be limited to people living below 300 percent of the FPL that have been uninsured for at least 12 months (***Figure 71***). Employer groups with 25 or fewer workers also would be permitted to enroll under three conditions including: 1) The firm must not have offered insurance in the past 12 months; 2) the employer must pay half of the premium; and 3) 75 percent of workers must enroll. In this scenario, it is assumed that the buy-in would use Medicare payment levels and have a $100 deductible ($200 family), which is estimated to cost $226 PMPM.

Under this scenario (i.e., scenario #1 in ***Figure 71***), it is estimated that about 8,200 people would become enrolled under the program. These include about 3,100 people purchasing coverage as an individual and about 6,700 workers and dependents who would be enrolled through a participating employer. Of the 8,200 people who would enroll, about 6,900 would be people who would have been uninsured in the absence of the program. The remaining 1,300 would be workers and dependents in participating firms that otherwise would have purchased non-group coverage in the individual market.

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 $22.2 million in 2003, which would be roughly equal to program costs. However, enrollment is expected to grow gradually over time as eligible people learn about the program.

The buy-in could be extended to people at higher income levels as well. Scenario # 1 targets uninsured people living below 300 percent of the FPL, because these individuals are perceived to be in the greatest need of assistance. However, the premiums for people attempting to purchase coverage in the individual market are often unaffordable to people above this income eligibility level as well. Therefore, the state could eliminate the income eligibility limit from the buy-in to open eligibility to others as well. Doing so would increase enrollment to 9,400 people, of whom 8,100 would be newly insured (i.e., scenario # 2 in ***Figure 71***).

Figure 71
Buy-in Enrollment Under Alternative Eligibility Criteria

	Scenario # 1	Scenario # 2	Scenario # 3	Scenario #4
Eligibility for Individuals	? Incomes Below 300% of FPL ? Uninsured 12 months unless job change or involuntary loss of coverage	? No income limit ? Uninsured 12 months unless job change or involuntary loss of coverage	? No income limit ? No waiting period	? No income limit ? No waiting period
Employer Eligibility	? 25 or fewer workers ? Have not insured in 12 months ? Employer pays half of premium ? 75% of workers enroll	? 25 or fewer workers ? Have not insured in 12 months ? Employer pays half of premium ? 75% of workers enroll	? 25 or fewer workers ? Have not insured in 12 months ? Employer pays half of premium ? 75% of workers enroll	? 25 or fewer workers ? No waiting period ? No employer payment requirement ? 75% of workers enroll
Program Enrollment and Cost Share [a/]				
Enrollment	8,191	9,379	11,995	31,694
Newly Insured	6,948	8,135	8,135	8,135
Premium Receipts (in millions)	$22.2	$25.4	$32.5	$85.9

a/ Assumes a policy with VHAP covered services at Medicare payment levels and a $100/$200 deductible. The monthly premium would be $226 compared to about $329 for similar private coverage. Premium payments are assumed to be equal to program expenses.

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

Under the first two scenarios, eligibility for both individuals and employers is restricted to only those who have been uninsured for at least 12 months. This is to prevent individuals and employers from discontinuing their current private insurance policy to become covered under the lower cost VHAP buy-in program. However, the state could open enrollment to all individuals and employers by eliminating the 12-month waiting period. If the waiting period were eliminated for both individuals and employers, enrollment would increase to 31,694 (i.e., scenario # 4). All of this increase in enrollment would be for people who drop their private coverage to enroll in the program. Additional detail on Lewin estimates under alternative benefits packages is presented in ***Figure 72.***

Figure 72
Enrollment and Costs under a Buy-in for Employers and Individuals in 2003 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)
Scenario #1: People Below 300 percent FPL and 12-month Waiting Period					
Employer Groups Only	6,654	5,409	$18.0	$18.0	$0.0
Individuals Only	3,061	3,061	$8.3	$8.3	$0.0
Both Employer Groups and Individuals	8,191	6,948	$22.2	$22.2	$0.0
Scenario #2: No Income Limit and 12-month Waiting Period					
Employer Groups Only	6,654	5,409	$18.0	$18.0	$0.0
Individuals Only	4,512	4,512	$12.2	$12.2	$0.0
Both Employer Groups and Individuals	9,379	8,135	$25.4	$25.4	$0.0
Scenario #3: No Income Limit and No Waiting Period for Individuals					
Employer Groups Only	6,654	5,409	$18.0	$18.0	$0.0
Individuals Only	7,128	4,512	$19.3	$19.3	$0.0
Both Employer Groups and Individuals	11,995	8,135	$32.5	$32.5	$0.0
Scenario #4: No Income Limit and No Waiting Period for Individuals and Employers					
Employer Groups Only	26,353	5,409	$71.5	$71.5	$0.0
Individuals Only	7,128	4,512	$19.3	$19.3	$0.0
Both Employer Groups and Individuals	31,694	8,135	$85.9	$85.9	$0.0

a/ Assumes full phase in of enrollment in 2003. Assumes an increase in VHAP provider payments to Medicare levels with a $100 deductible ($200 family). The premium would be $226 in 2003. Comparable coverage under BlueCare Program A would cost about $329 per month in 2003.

b/ Assumes premiums are adjusted to equal total program costs.

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

F. Programs to Assist Families in Purchasing Private Coverage

Congress has been considering proposals that would provide assistance to individuals purchasing coverage in the non-group market. Under current law, the amount spent by employers to provide

health benefits is not taxable to the employee even though this is a form of income to the worker. This is a substantial tax subsidy to those receiving coverage from their employer, which equals an average of about $2,000 per worker family.[44] However, individuals who do not have access to employer-sponsored health insurance who must purchase non-group coverage on their own receive no tax benefits.

Some consider this to be a substantial inequity in the tax code. In addition, those without employer-provided health insurance must seek coverage in the non-group market where premiums are typically higher than in the group market.

There are several federal proposals that would provide a tax credit to people purchasing non-group coverage. The tax credit is designed to both encourage these individuals to purchase coverage, and to promote equitable tax policy. To illustrate the impact of such a program, Lewin analyzed an illustrative tax credit typical of those being considered by Congress and the executive branch in the summer of 2001. The tax credit would be available to people purchasing non-group coverage and who do not have access to employer-provided coverage. The credit would be limited to people with incomes below 300 percent of the FPL.

In this illustration, the tax credit would equal specified dollar amounts, such as $1,000 for single individuals and $2,000 for families. The credit would be capped at the amount actually spent on health insurance by the taxpayer. However, the credit would be "refundable", which means the amount of the credit can exceed the amount owed in taxes during a year. This assures that people with too little income to be required to pay income taxes could receive the full amount of the credit. In addition, it is assumed that the tax credit is phased out on a sliding scale with income for people with incomes between 200 percent and 300 percent of the FPL. Lewin analyzed three credit amount scenarios including:

? Credit amount of: $750 for individuals, and $1,500 for families;

? Credit amount of: $1,000 for individuals, and $2,000 for families;

? Credit amount of: $1,250 for individuals, and $2,500 for families.

Lewin estimates that there would be about 47,000 people in Vermont families that qualify for the credit (***Figure 73***)**.** These include people without access to employer-sponsored health insurance who are living below 300 percent of the FPL. Of these, about 26,400 are currently purchasing non-group coverage and about 20,600 people are currently uninsured. In this analysis, it is assumed that all eligible people who are currently purchasing non-group coverage (26,400) would receive the credit. It is also estimated that up to about 7,700 of the 20,260 eligible uninsured people would be induced to purchase coverage with the help of the credit. Thus, the impact of offering a $1,000 tax credit to individuals and a $2,000 tax credit to families would be a reduction of the number of uninsured in the state by about 7,700 people.

[44] John Sheils et. Al. "Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy", (report to the National Coalition on Health Care (NCHC)), October 18, 1999.

Figure 73
Cost and Coverage Impacts of a Tax Credit for Individuals Purchasing Non-group Coverage

	Eligible	Enroll	Newly Covered	Total Cost (in millions)	Cost per Enrollee	Cost per Newly Insured
$750/$1,500						
Currently Insured	26,400	22,700	- -	$13.4	$595	
Uninsured	20,600	6,624	6,624	$3.0	$658	
Total	**47,000**	**29,324**	**6,624**	**$16.4**	**$596**	**$3,417**
$1,000/$2,000						
Currently Insured	26,400	22,700	- -	$17.8	$784	
Uninsured	20,600	7,728	7,728	$4.8	$865	
Total	**47,000**	**30,428**	**7,728**	**$22.6**	**$797**	**$4,036**
$1,250/$2,500						
Currently Insured	26,400	22,700	- -	$20.9	$921	
Uninsured	20,600	9,522	9,522	$7.1	$1,029	
Total	**47,000**	**32,222**	**9,522**	**$28.0**	**$943**	**$4,058**

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

The number of uninsured people who would become covered will vary with the amount of the credit. For example, with a credit amount of $750 for individuals and $1,500 for families, about 6,600 uninsured people would purchase coverage. When the credit is increased to $1,250 for individuals and $2,500 for families, about 9,500 uninsured people would become covered.

It is important to note that most of the tax credit dollars would go to people who already have coverage. For example, under the $1,000/$2,000 tax credit scenario, total tax credit payments would be $22.6 million, of which, $17.8 million would go to people who are already purchasing coverage under current tax law.

G. Subsidies to Help Employers Purchase Coverage for Their Workers

An alternative approach to expanding coverage would be to provide subsidies directly to employers to help them provide coverage to their workers. This could be accomplished through a refundable tax credit to employers who are not now providing coverage. Existing proposals for an employer tax credit would set the amount of the tax credit equal to a percentage of the employer's expenditures for employee health benefits (e.g., 25 to 40 percent).[45]

To illustrate the potential impact of this approach, Lewin estimated the coverage and cost impacts of an employer tax credit for employee health coverage that is targeted towards small employers with low-wage workers. Eligibility would be restricted to: (1) firms that have not

[45] John F. Sheils, "Health Coverage 2000: Cost and Coverage Analysis of Eight Proposals to Expand Health Insurance Coverage" (report to the Robert Wood Johnson Foundation (RWJF)), September 2000.

provided coverage for at least 12 months; and (2) firms with an average payroll below the average for small firms in the state. These firms would receive these tax credits for a period of three to five years as long as the firm continues to meet the firm size and average payroll eligibility criteria. (The dollar amount of the credit could also be phased-out with percentage reductions each year over the three to five year period.)

In the first scenario, it is assumed that the credit is limited to only firms with 10 or fewer workers. The amount of the credit is assumed to be equal to 25 percent of the employer's expenditures for health benefits. Lewin also estimated the impact of alternative scenarios of eligibility by firm size and tax credit amounts including:

? Firms with 10 or fewer workers - 25 percent credit;

? Firms with 10 or fewer workers - 40 percent credit;

? Firms with 25 or fewer workers - 25 percent credit;

? Firms with 25 or fewer workers - 40 percent credit.

Lewin estimates that there are about 12,700 workers and dependents in firms with 10 or fewer workers in Vermont that would be eligible for the credit (***Figure 74***). These include firms with under 10 workers who have not offered insurance for 12 or more months that also have an average payroll per worker (i.e., full-time equivalent worker) that is less than the average for firms of this size. Of these 12,700 people, about 5,500 are currently uninsured, while about 7,200 already have insurance from some other source (i.e., on-group coverage, dependent of working spouse with employer coverage, etc.).

Assuming the credit is equal to 25 percent of employer costs, it is estimated that about 4,600 workers and dependents would be in firms that are induced to obtain coverage. Of these, 2,500 would be people who otherwise would be uninsured. The total cost of the credit to the state would be $1.9 million.

The state could increase the number of firms that are induced to offer coverage by increasing the credit amount. For example, increasing the amount of the credit to 40 percent of the employer's health benefits costs would increase the number of uninsured people who become covered to about 3,400 people at a total cost of about $4.1 million. In addition, extending the 40 percent tax credit to all firms with under 25 workers (i.e., who meet the average salary requirement) would cover about 4,400 people who otherwise would be uninsured at a cost of $5.0 million (***Figure 74***).

H. Create Low-cost Health Insurance Coverage Options

The state could also expand coverage by subsidizing the cost of a low-cost health insurance product for employers who currently do not provide coverage. In this analysis, Lewin examined the potential impact of creating in Vermont a program modeled on the "Healthy New York" program recently implemented in New York State. This program permits lower income

Figure 74
Cost and Coverage Impacts of Alternative Tax Credits for Small Employers with Low-wage Workers

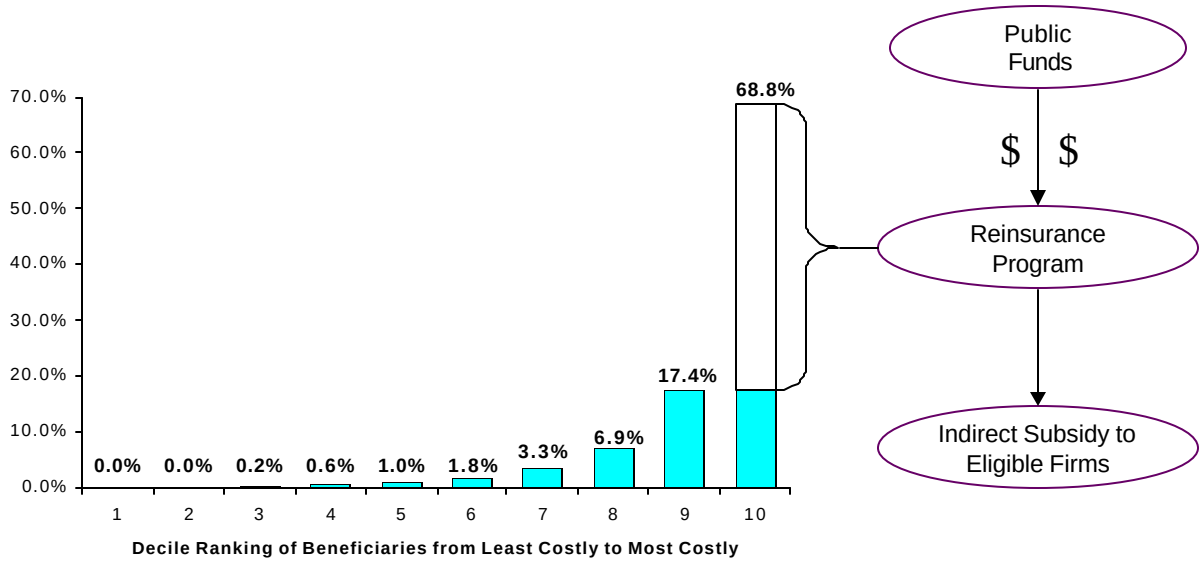
	Eligible	Enroll	Newly Covered	Total Cost (in millions)	Cost per Enrollee	Cost per Newly Insured
Under 10 Workers						
25 percent Credit						
Currently Insured	7,200	2,100	- -	$1.0	$483	
Uninsured	5,500	2,484	2,484	$0.9	$494	
Total	**12,700**	**4,584**	**2,484**	**$1.9**	**$487**	**$1,045**
40 percent Credit						
Currently Insured	7,200	2,800	- -	$2.1	$790	
Uninsured	5,500	3,450	3,450	$2.0	$810	
Total	**12,700**	**6,250**	**3,450**	**$4.1**	**$799**	**$1,712**
Under 25 Workers						
25 percent Credit						
Currently Insured	9,300	2,700	- -	$1.2	$451	
Uninsured	7,200	3,312	3,312	$1.1	$463	
Total	**16,500**	**6,012**	**3,312**	**$2.3**	**$457**	**$966**
40 percent Credit						
Currently Insured	9,300	3,500	- -	$2.6	$742	
Uninsured	7,200	4,416	4,416	$2.4	$761	
Total	**16,500**	**7,916**	**4,416**	**$5.0**	**$751**	**$1,588**

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

individuals and employers with lower-wage workers to purchase a private health plan that does not include mandated benefits. The state also effectively subsidizes premiums for eligible employers and individuals in these plans through a modified reinsurance system.

The state subsidy is provided through a reinsurance mechanism that pays a substantial percentage of health benefits costs for high-cost cases among the eligible individuals and employers who purchase such a policy. As shown in ***Figure 75,*** about 70 percent of all costs under a typical health plan are associated with just 10 percent of the covered population. This program subsidizes the cost of coverage for many of these high-cost cases, resulting in lower premiums. Under the Healthy New York program, the state reinsurance program pays 90 percent of costs in excess of $30,000 for each person covered under these plans up to a maximum covered amount of $100,000 per member. The cost of this reinsurance is paid through trust funds established for this purpose using New York tobacco settlement receipts.

Figure 75
Subsidized Insurance for Small Groups Through State-funded Reinsurance



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

In New York, it is estimated that premiums under the program will be reduced by about 15 to 20 percent. About half of this amount is attributed to the elimination of mandated benefits, with the other half attributed to the reinsurance subsidy. This reduction in costs is designed to increase the number of employers and individuals with insurance. The program, which was implemented in January 2001, currently has about 3,000 members.

In this analysis, Lewin estimated the impact of adopting a similar program in Vermont using the eligibility criteria used in the Healthy New York program. Self-employed people and other individuals would be eligible if they have been uninsured for 12 or more months and their income is less than 250 percent of the FPL. Eligibility for employers is limited to firms meeting the following criteria:

? Firms with 50 or fewer workers;

? At least half of employees enroll in the plan;

? Have not offered coverage in 12 or more months;

? Less than 30 percent of employees are earning over $30,000; and

? The employer pays half of the premium.

This program would have less of an impact on premiums in Vermont than it will in New York because Vermont has fewer mandated benefits than New York. Thus, only the reinsurance subsidy would have a significant impact on premiums in Vermont. For purposes of developing

estimates for Vermont, Lewin assumed that the program would reduce premiums for participating firms and individuals by about 15 percent.

Lewin estimates that in response to these premium reductions, about 4,000 people would take coverage under these health plans. This includes both individuals and people in firms that are induced to purchase this subsidized coverage (***Figure 76***). Of these, nearly all would be people who otherwise would have been uninsured. The total cost to the state of the reinsurance program would be $860,000.

Figure 76
Low-cost Coverage Options for Non-insuring Firms with Less than 25 Workers

	Number Enrolled	Newly Insured	State Cost (in thousands)
Three-year Exemption from Mandatory Benefits Only	1,350	1,350	- -
State-funded Reinsurance Only	2,700	2,700	$573
Mandatory Benefits Exemption with State-funded Reinsurance	4,050	4,050	$860

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

I. A Single-Payer Model for Vermont

As part of the State Planning Grant Program, Lewin estimated the impact of a single-payer program in which all state residents are covered under a single public program funded primarily with an employer payroll tax. Lewin estimated the financial impact of a single-payer program on various payers for health care including state, local, and federal governments. It is also estimated the financial impact of the proposal on employers by industry and firm size. In addition, estimates of the impact of the plan on household health spending by age, income level, and other characteristics are presented.

1. The Single-Payer Proposal

The single-payer model is a system where all individuals in the state are covered under a single uniform health plan that is administered and funded by the state. The new single-payer system would replace all current public-sector insurance systems including: Medicare, Medicaid, CHAMPUS and the Federal Employees Health Benefits Plan (FEHBP). It would also replace private health insurance plans in the state. The program would be financed with current government health care funding for discontinued programs and new taxes on employer payroll.

The single-payer benefits package assumed in this analysis is modeled on the benefits typically provided under employer health plans. The program would cover medically necessary inpatient hospital care, physician services (including preventive care), hospital outpatient care, prescription drugs, lab tests, and mental health services (including substance abuse and tobacco cessation). Chiropractic services would be covered when referred by a physician. The program

would cover preventive dental care and vision exams, but it would not cover orthodontia, private rooms, or eyeglasses.

To discourage over-use of services, there would be a $10.00 copayment for ambulatory care services. There would be no deductible. Also, the program would use a primary care provider referral (i.e., gatekeeper) model where patients face increased copayments for visits to specialists without referral. Benefits that are currently provided to Medicaid eligible people that are not covered under the single-payer model would be continued for low-income people who qualify for Medicaid under current eligibility rules.

2. Health Spending Under The Single-Payer Program

The Lewin Group estimated that total health spending for Vermont residents under the current system would be $2.2 billion in 2001. This includes spending for all health care services including benefits payments and insurer administration. The analysis indicated that the single-payer program would achieve universal coverage while actually reducing total health spending by about $118.1 million in 2001 (***Figure 77***). The primary reason for this savings reduction is that the single-payer model substantially reduces the cost of administering health insurance coverage, resulting in savings that can be used to pay for the care that would be provided to people who are currently going without coverage.

Lewin estimates that under current trends, about 51,390 Vermont residents would be without health insurance in 2001. It is estimated that their use of health services would increase by $23.1 million if they were to become covered under the benefits package described above. Also, utilization would increase among currently insured people who currently do not have coverage for certain services such as prescription drugs or preventive dental care by about $39.8 million. Thus, the total increase in utilization of heath services among the uninsured and the under-insured people would be $62.9 million in 2001.

In addition, there would be a net increase in spending of about $2.8 million due to changes in the use of managed care under the program. Lewin also assumed that the government plan would receive higher prescription drug rebates similar to the current rebates received under the State's Medicaid program. These rebates are estimated to be about $30.2 million in 2001.

The cost of these increases in utilization for uninsured and under-insured people would be more than offset by reduced administrative costs under the program. The single-payer system replaces the current system of multiple public and private insurers with a single source of payment for all covered services. This eliminates the complexity of both diverse insurer rules and patient billing for unreimbursed amounts. The single-payer system also replaces hospital billing for individual patients with annual operating budgets, which effectively eliminates claims filing functions for Vermont hospitals. (Claims filing would continue for out-of-state patients.)

Figure 77
Changes in Health Spending in Vermont under a Single-Payer Program in 2001
(in millions) [a/]

		Changes in Spending
Changes in Health Services Utilization		
Increase in Utilization Due to Expanded Coverage		$62.9
Utilization Increase for Previously Uninsured	$23.1	
Expanded Coverage for Those Already Insured	$39.8	
Change in Administrative Costs		
Net Change in Administrative Costs		($153.6)
Insurer Administration (Includes Administration for Newly Insured)	($106.5)	
Physician Administrative Savings	($19.8)	
Hospital Administrative Savings	($27.3)	
Managed Care Adjustment		
Managed Care Adjustment [b/]		$2.8
Prescription Drug Rebate		
Prescription Drug Rebate [b/]		($30.2)
Net Change in Health Spending		
Net Change in Health Spending		($118.1)

a/ Includes all people in the state including those with public and private coverage.
b/ Assumes an increase in utilization for people currently covered under HMO plans and an adjustment for higher prescription drug rebates under the government plan.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM)

The single-payer approach would also substantially reduce claims-filing costs for physicians by standardizing the means of reimbursement through a single-payer and by providing full reimbursement through a single source using a standardized electronic claims-filling process. Standardization of coverage would also reduce physician costs related to adjudication of claims and negotiation of selective-contracting arrangements. Total savings to providers would be about $47.1 million. Lewin assumed that provider payments are reduced by this amount so that these savings accrue to payers.

The single-payer program would extend large-group economies of scale for administration of insurance throughout the health care system by covering all individuals under a single insurance mechanism. This would eliminate the costs associated with underwriting, transition in coverage, and maintaining the linkage between employers and insurers. Overall, statewide insurer administrative costs would be reduced from $173 million under current policy to $67 million under the single-payer model for a net savings of about $106.5 million in 2001**.**

3. Impact on Employers

Health coverage for workers and their dependents under the single-payer model would be financed with a payroll tax, two-thirds of which would be paid by the employer with the rest paid

by the worker. There would be no premiums for the benefits provided under the standard benefits package. Lewin estimates that the payroll tax rates required to fully fund benefits for workers and dependents under the single-payer model would be 5.8 percent for employers and 2.9 percent for employees.

Under these tax rates, total employer health spending in Vermont would increase by $123.2 million in 2001 (***Figure 78***)**.** This includes $119.6 million in payments by firms that currently do not offer coverage. Employer health spending for firms that currently offer health insurance to their workers would increase by about $3.6 million. Currently insuring firms would realize savings attributed to reduced spending for retirees as Medicare beneficiaries are shifted from their current Medicare benefits plan to the more comprehensive benefits package provided under the single-payer model. Employer costs would increase by an average of $1,452 per worker for workers in firms that do not now offer coverage while costs for firms that currently offer coverage would increase an average of only $20 per worker.

Figure 78
Change in Private Employer Costs Under the Single-Payer Model in Vermont in 2001

	Change In Health Spending (in millions)	Change in Health Spending Per Worker
Before Wage Effects		
Firms That Now Offer Insurance	$3.6	$20
Firms That Do Not Now Offer Insurance	$119.6	$1,452
All Firms	**$123.2**	**$479**
After Wage Effects[a/]		
Firms That Now Offer Insurance	($30.1)	($172)
Firms That Do Not Now Offer Insurance	$0.0	$0.0
All Firms	**($30.1)**	**($117)**

a/ Employers are assumed to pass-on the savings and/or increases in cost under the single-payer plan to workers in the form of changes in wages as labor markets adjust to these changes in employee compensation.
Source: Lewin Group Estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

However, economic theory and research indicates that over time increases in employer costs for health and other benefits are typically passed on to workers in the form of reduced wage growth. Thus, it is assumed that over the long-term, all of the changes in employer costs for workers under the single-payer plan will be passed on to workers in their wages as labor markets adjust to reflect changes in total employee compensation costs under health reform. Employers are expected to retain any savings in benefits costs for retirees. This is because these savings are attributed to compensation packages for prior workers, which does not affect the labor market for

current workers. Overall, private employers would save about $30.1 million in retiree costs under the single-payer model.

4. Household Impacts

Under a single-payer program, Vermont residents would no longer pay health insurance premiums and would face only $10.00 co-payments for health services. Instead, households would pay taxes on their earnings. In addition, household incomes would be affected by wage adjustments resulting from increased employer spending for health care (i.e., the employer payroll tax). These changes in the way in which care is financed would substantially alter the distribution of health care costs across households of various age and income groups.

Lewin estimates that household health spending would decline by $122.3 million under the single-payer program. This includes the elimination of household premium payments for private health insurance ($321.8 million); and reduced household out-of-pocket payments for health services ($218.8 million). These savings would be offset by increased tax payments of $307 million. In addition, Lewin estimates a loss of wages to households (after tax offsets) of about $111.3 million as employers pass-on the increased cost of complying with the payroll tax to workers in the form of reduced wages.

Overall, Lewin estimates that households would see health spending decrease by an average of about $441 per family under the single-payer model in 2001 (***Figure 79***) In general, the single-payer plan would tend to reduce health care costs for lower- and middle-income families. For example, families with under $75,000 in annual income would, on average, see savings. However, health spending for families with $150,000 or more in income would increase by about $4,490 per family. This reflects the fact that the program shifts Vermont residents away from a premium-financed system, to a tax-financed system where total health spending would be in proportion to family earnings.

Savings under the single-payer plan would tend to be greatest for older individuals. For example, families headed by an individual age 65 or older would save about $1,575 per family (***Figure 80***). By contrast, average health spending would decrease by only $171 per family for younger age groups. On average, household savings would be greatest for families facing high out-of-pocket costs under current policy.

J. Comparison of Policy Alternatives

Figure 81 presents a summary of the estimated cost and coverage impacts of the options analyzed in this study. For each policy option, this includes estimates of the number of people who would enroll, the reduction in the number of uninsured, net new state expenditures under the proposal, the percentage of children and adults with coverage under the proposal and costs per newly insured person. After reviewing these options, the steering Committee narrowed down the options for further consideration as shown in ***Figure 82***.

Figure 79
Change in Average Household Health Spending in Vermont Under the Single-Payer Model in 2001: After Wage Effects [a/ b/]

Family Income	Single-Payer
Less than $10,000	($608)
$10,000 - $14,999	($721)
$15,000 - $19,999	($1,000)
$20,000 - $29,999	($1,038)
$30,000 - $39,999	($1,238)
$40,000 - $49,999	($1,397)
$50,000 - $74,999	($995)
$75,000 - $99,999	$58
$100,000 - $149,999	$933
$150,000 or More	$4,490
All Families	**($441)**

a/ Excludes institutionalized people.
b/ Includes changes in premiums, out-of-pocket expenses, taxes earmarked to fund health reform, and after-tax wage effects.
Source: Lewin Group Estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

Figure 80
Change in Average Family Spending on Health Care in Vermont Under the Single-Payer Model in 2001 by Family Income and Age of Household Head: After Wage Effects [a/ b/]

	Average Change by Age of Householder		
Family Income	**Under Age 65**	**Age 65 and Older**	**All Families**
Less than $10,000	($450)	($1,006)	($608)
$10,000 - $14,999	($296)	($1,396)	($721)
$15,000 - $19,999	($543)	($1,961)	($1,000)
$20,000 - $29,999	($837)	($1,567)	($1,038)
$30,000 - $39,999	($1,001)	($2,482)	($1,238)
$40,000 - $49,999	($1,232)	($2,351)	($1,397)
$50,000 - $74,999	($853)	($2,081)	($995)
$75,000 - $99,999	$229	($1,928)	$58
$100,000 - $149,999	$1,191	($1,732)	$933
$150,000 or More	$4,861	$(357)	$4,490
All Families	**($171)**	**($1,575)**	**($441)**

a/ Excludes institutionalized people.
b/ Includes changes in premiums, out-of-pocket expenses, taxes earmarked to fund health reform, and after tax wage effects.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

Figure 81
Summary of Cost and Coverage Impacts for Coverage Expansion Options Studied for Vermont

	Number Enrolled	Reduction in Uninsured People	Net New State Costs (in millions)	Percentage of Children Covered	Percentage of Adults Covered	Percentage of People Below 300% FPL Who Are Covered	State Cost Per Enrollee	State Cost Per Newly Insured Person
Current Coverage								
Current Coverage	- -	- -	- -	95.8%	90.2%	88.9%	- -	- -
Income Eligibility Expansion for Parents under VHAP								
Cover Parents Between 185% and 225% of FPL	1,500	552	$1.0	96.0%	90.3%	89.1%	$666	$1,811
Cover Parents Between 185% and 300% of FPL	4,400	1,242	$1.9	96.2%	90.5%	89.3%	$432	$1,530
Income Eligibility Expansion for Non-custodial Adults under VHAP								
Non-custodial Adults Between 150% and 185% of FPL	4,500	4,278	$9.5	95.8%	91.1%	90.2%	$2,111	$2,220
Non-custodial Adults Between 150% and 225% of FPL	6,800	5,934	$14.6	95.8%	91.5%	90.7%	$2,147	$2,451
Non-custodial Adults Between 150% and 300% of FPL	8,600	6,624	$15.4	95.8%	91.6%	90.9%	$1,790	$2,325
Other Medicaid Options								
VHAP Buy-in for Employers of Low-Wage Workers and People Below 300% of FPL	7,668	6,503	$0.0	96.2%	91.5%	90.4%	$0	$0
Expanded Outreach for Children	2,457	2,457	$0.7	97.5%	90.2%	89.7%	$203	$203
Outreach for Adults	7,549	7,549	$9.9	95.8%	91.8%	92.8%	$1,331	$1,331
Buy-in to Employer-Sponsored Coverage for VHAP Children	832	355	($0.2)	96.0%	90.2%	89.1%	($240)	($563)
Premium Subsidies for People Below 300% of the FPL without Access to Other Coverage (subsidy phase out between 225% and 300% of FPL)								
Subsidy of $750 for Individuals, $1,500 for families	27,500	6,624	$16.4	96.8%	91.3%	90.9%	$596	$2,476
Subsidy of $1,000 for Individuals, $2,000 for families	28,200	7,728	$22.6	97.0%	91.5%	91.2%	$801	$2,924
Subsidy of $1,250 for Individuals, $2,500 for families	29,600	9,522	$28.0	97.2%	91.8%	91.7%	$946	$2,940
Employer Tax Credit for Non-insuring Firms (for 12 months) with Average Payroll Below State Average for Small Firms								
Firms under 10 Workers: 25 Percent Credit	3,900	2,484	$1.9	96.2%	90.6%	89.4%	$487	$765
Firms under 10 Workers: 40 Percent Credit	5,500	3,450	$4.1	96.3%	90.8%	89.6%	$745	$1,188
Firms under 25 Workers: 25 Percent Credit	5,100	3,312	$2.3	96.3%	90.7%	89.7%	$451	$694
Firms under 25 Workers: 40 Percent Credit	6,700	4,416	$5.0	96.5%	90.9%	90.0%	$746	$1,132
Create Low-cost Coverage Options for Non-insuring Firms with Less than 25 Workers (for 12 months)								
Three-year Exemption from Mandatory Benefits (assumes 5 percent savings)	1,350	1,350	- -	96.0%	90.4%	88.8%	$0	$0
Mandatory Benefits Exemption with State-Funded Reinsurance Program (90% coverage for cases Over $25,000)	4,050	4,050	$0.9	96.4%	91.0%	89.5%	$222	$222
Single Payer Program								
Basic Benefits Model (i.e., copayments with gatekeeper model)	609,000	51,390	$0.9 billion	100.0%	100.0%	100.0%	$1,559	$18,486
No Cost-sharing Model (i.e., no copayments or gatekeeper program)	609,000	51,390	$1.3 billion	100.0%	100.0%	100.0%	$2,167	$25,685

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

Figure 82
Summary of Cost and Coverage Impacts for Selected Coverage Expansion Options in Vermont

	Number Enrolled	Reduction in Uninsured People	Net New State Costs (in millions)	Percentage of Children Covered	Percentage of Adults Covered	Percentage of People Below 300% FPL Who Are Insured	State Cost Per Enrollee	State Cost Per Newly Insured Person
Current Coverage								
Current Coverage Levels	- -	- -	- -	95.8%	90.2%	88.9%	- -	- -
VHAP Expansion Options								
Expand VHAP to Cover All Adults Through 300 Percent of the FPL	13,000	7,866	$17.3	96.2%	91.8%	91.3%	$1,331	$2,199
Outreach for Children's Coverage (assumes 50 percent effective)	2,457	2,457	$0.7	97.5%	90.2%	89.7%	$203	$203
Outreach for Adult Coverage (assumes 50 percent effective)	7,549	7,549	$9.9	95.8%	91.8%	92.8%	$1,331	$1,331
Buy-in to VHAP for Low-Wage Employers and People Below 300% of FPL	7,668	6,503	$0.0	96.2%	91.5%	90.4%	$0	$0
State Buy-in to Employer Coverage for Dr. Dynasaur Children	832	355	($0.1)	96.0%	90.2%	89.1%	($123)	($391)
Private Coverage Expansion Options								
Employer Tax Credit for Non-insuring Firms with Fewer than 25 Workers Equal to 40 Percent of Employer Costs	6,700	4,416	$5.0	96.5%	90.9%	90.0%	$746	$1,132
Create Low-cost Insurance Option	4,050	4,050	$0.9	96.4%	91.0%	89.5%	$222	$222
Single-Payer Model								
Basic Benefits Model	609,000	51,390	$950.4	100.0%	100.0%	100.0%	$1,559	$18,486

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

These policy options were compared on the basis of their impact on the percentage of the population without insurance coverage. The BISCHA survey of households in Vermont indicates that about 91.6 percent of all people in the state have insurance coverage from some source. About 95.8 percent of children are covered and about 90.2 percent of adults are covered. In addition, about 88.9 percent of Vermonters living below 300 percent of the FPL are insured.

All of the options considered would result in some reduction in the number of people 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 were outreach programs to enroll people who are already eligible for Medicaid/VHAP/Dr. Dynasaur who have not yet enrolled. Lewin estimated that an aggressive outreach program could raise the coverage level for children to 97.5 percent and the coverage level for adults in the state to 91.8 percent. Under the outreach option, about 92.8 percent of all people living below 300 percent of the FPL would be covered.

Analysis indicates that higher levels of coverage could be achieved by combining certain policy options. For example, if the state 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 (***Figure 83***)**.** Adding the VHAP buy-in program would increase coverage for adults to 94.5 percent.

The state 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 fewer 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.

The state could also implement the full range of VHAP expansion and buy-in options together with the employer tax credit and the low cost insurance product. This scenario would reduce the number of uninsured by about 22,200 people, which is equal to about 43 percent of Vermont's uninsured population. Coverage under this combined policy would reach 98.0 percent among children and 95.3 percent among adults. The total state costs would be about 31.4 million, which is equal to about 1,400 per newly insured person. An analysis of reserve requirement for a buy-in program is presented in ***Appendix E***.

K. Test Marketing

Based upon these analyses, the steering committee selected several options to be "test marketed" with uninsured people and employers. Action Research Inc. implemented this through a series of focus groups of uninsured people and employers. The results of these focus group sessions is presented in ***Appendix G***. The options selected for test marketing were:

Figure 83
Summary of Cost and Coverage Impacts for Selected Combinations of Expansion Options in Vermont

	Number Enrolled	Reduction in Uninsured People	Net New State Costs (in millions)	Percentage of Children Covered	Percentage of Adults Covered	Percentage of People Below 300% FPL Who Are Insured	State Cost Per Enrollee	State Cost Per Newly Insured Person
Current Coverage								
Current Coverage Levels	- -	- -	- -	95.8%	90.2%	88.9%	- -	- -
VHAP Expansion Options								
Expand VHAP to 300 Percent of FPL with Outreach for Currently Eligible Children and Adults	23,024	18,227	$27.7	97.5%	93.6%	94.6%	$1,200	$1,540
ALL VHAP Expansion Options with VHAP Buy-In								
VHAP Buy-In [a/]	25,536	20,373	$27.7	97.8%	94.5%	94.6%	$933	$1,376
Combined Private Sector Options								
Employer Tax Credit with Low Cost Insurance Product	7,510	5,226	$5.8	96.7%	91.1%	89.9%	$772	$1,110
All Public and Private Options Combined								
All VHAP Expansions, VHAP Buy-In, Tax Credits and Low-Cost Product	29,199	22,160	$31.4	98.0%	95.3%	94.7%	$1,075	$1,380

a/ Due to the expansion in eligibility to 300 percent of the FPL, the buy-in would apply primarily to employers.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

? **Direct Care Model:** The purpose of this program is to expand the availability of free or subsidized health care for needy individuals who continue to be uninsured. Uninsured people who present themselves at hospitals would be permitted to obtain services from participating physicians during regular business hours in the physician's office. Participants would be required to pay for a portion of the services provided on a sliding scale with income for people below 300 percent of the FPL (i.e. about $55,000 for a family of four). Case management would be provided for people with chronic conditions.

? **Medicaid Eligibility Expansion:** Income eligibility levels for the VHAP program would be increased to 300 percent of the federal poverty level (FPL) for all Vermont residents. This corresponds to annual income of roughly $35,000 for a single individual and $55,000 for a family of four. Because children through 300 percent of the FPL are already covered under Dr. Dynasaur, this would affect primarily adults between the current VHAP eligibility level and 300 percent of the FPL. (The current VHAP eligibility is 185 percent of the FPL for parents living with children; and 150 percent of the FPL for adults without children.)

? **VHAP buy-in to Employer Sponsored Health Plans:** The purpose of this proposal is to enroll Dr. Dynasaur eligible children in a parent's employer sponsored health plan in cases where such coverage is available. Under this option, the state would identify children eligible for Dr. Dynasaur who also have a parent with access to employer sponsored coverage where they work. The state would pay the premium contribution required to obtain family coverage under the employer plan in instances where this is less costly to the state than covering the children under Dr. Dynasaur. [46]

? **Employer Health Insurance Tax Credits:** The purpose of this program is to assist small employers with low-wage workers in obtaining coverage for their employees. The program would provide a refundable tax credit to eligible employers equal to the 25 to 40 percent of the employer's cost of coverage (e.g., premiums paid less the amount paid by employees).[47] The tax credit would be available to firms meeting the following eligibility criteria:

  ? Firms with 25 or fewer employees;

  ? Must not have provided coverage in the past 12 months; and

  ? Has average salaries/wages per employee below the statewide average

? **Develop Low Cost Insurance Product:** The purpose of this option is to make a low-cost health insurance product available to small firms that do not now provide coverage to their employees. Eligible employers would be permitted to purchase a private insurance policy that is exempt from state mandated benefit requirements and is subsidized with state funds.[48] The benefits excluded from the plan for eligible firms include chiropractic, home health, drug and

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[46] The amount paid to the employer would be equal to the difference between the contribution amount required for family coverage and the contribution amount required for single coverage under the plan.

[47] The tax credit would be refundable, which means that eligible employers would receive the tax credit even if they did not earn enough to pay taxes.

[48] The state funded subsidy would be in the form of a "re-insurance" program where the state pays 90 percent of the cost of benefits payments in excess of $30,000 for people covered under such a plan.

alcohol treatment, mental health and others. The plan would have a $500 deductible with a lifetime benefits limit of $100,000. Eligible firms include those that meet the following criteria:

? The employer has 50 or fewer workers with at least half enrolling in the plan;

? The employer has not provided coverage in the past 12 months;

? Less than 30 percent of the workers are earning over $30,000; and

? The employer pays at least half the premium

1. Test Marketing with Uninsured

As with other groups, consumers without health insurance found the policy options difficult to digest and understand. Much of the time during the groups was spent describing and explaining different elements of the plans, rather than discussing the merits and drawbacks. However, the uninsured groups did seem to have a clearer grasp of certain of the concepts, specifically the Direct Care Model and the policies involving VHAP or Dr. Dynasaur. This is most likely because these groups are already familiar with the services. Participants tended to personalize their evaluations of the coverage options, often indicating preferences for options in terms of how beneficial the policy would be for their individual situation.

a. Direct Care Model

This coverage option was described as one that would "expand the availability of free or subsidized health care for the uninsured." It was described as a plan that would allow uninsured individuals to obtain medical care at a physician's office and would require some participants to pay for a portion of services based on a sliding fee scale.

Although consumers without health insurance were less confused about how the Direct Care Model would work than other groups, these participants did find parts of the description confusing and had many questions about how this policy option would work.

Participants were confused in thinking that the hospital would be the intake point for integrating uninsured Vermonters into the system. Participants thought this would mean that individuals would have to go to the hospital or emergency room each time they wanted to see the doctor, or that uninsured individuals would be denied care at emergency rooms and be told to see a physician during regular business hours.

Focus group participants suggested that there be other ways of getting the uninsured involved in the Direct Care Model, such as intake points at clinics, or an office that the uninsured could call or visit to apply for the program. Other suggestions included application by telephone or mail. Participants were particularly concerned that hospital staff would not have the time to properly screen individuals, process applications and distribute information on the program.

Participants were also confused about the income requirements for participation. Some thought that the sliding scale fee-for-service would apply to those whose household income was *no lower than* $53,000. Others were confused by this policy option because they did not understand that it is not intended to be a health insurance policy. Some wanted to know if pre-existing conditions would be covered under this plan.

Similar to the other groups, the uninsured participants also questioned whether it is feasible to assume that doctors would participate in such a plan. Participants wanted to know how the doctors would get paid for their services, what the reimbursement rates would be and how doctors could afford to treat people if they were not being fully paid for their services. All in all, there was skepticism about doctors' willingness to participate in the Direct Care Model.

Other concerns included who the participating doctors would be and what would happen in areas where no physician was willing to participate in such a plan. Would the Direct Care Model require that people have to travel far to obtain medical services from participating providers? What if a participant needed to see a specialist? How does this program address the cost of prescription drugs?

Uninsured participants raised one slightly different question about this policy option than was raised in the employer groups. They were concerned about the amount of paperwork that would be involved in participating in the program and how long it would take to get people integrated into the system.

However, despite their questions about the option, participants were generally very favorable toward the concept. They particularly liked the idea of being able to pay for services on a sliding scale fee-for-service basis. Participants in Middlebury indicated that a variation of this model exists now. They also note that they believe it is just not publicized well enough. They state that the existing program is not widely known about nor is information offered up to patients.

b. Medicaid Eligibility Expansion

This coverage option was described as one that would "increase the income eligibility levels for VHAP to 300 percent of the federal poverty level (FPL) for all Vermont residents." The description noted that, since children whose parents earn up to 300 percent of FPL already qualify for Dr. Dynasaur, this plan would primarily affect adult Vermonters.

Overall, consumers without health insurance were favorable toward the idea of expanding Medicaid eligibility. Many participants believe that this plan will directly benefit more people than the other plans. Additionally, they see that Medicaid Eligibility Expansion is targeted toward the groups who need the most help – families with kids and low-income Vermonters. Participants also liked the idea that, rather than instituting a new program, this policy option builds on programs already in place.

Some participants did not like the idea of a gradual expansion of the program. Some felt that individuals without children should not have to wait for their coverage to begin, others questioned why the FPL eligibility requirements should be different for those with children and

those without. Overall, participants agree that help is needed for all Vermonters, sooner rather than later.

Participants expressed concern about the expansion of eligibility and the reimbursement rates for doctors. Participants note that, because reimbursement rates are low, doctors will not be willing to take on new VHAP patients. A few participants mention that an expansion of eligibility should be accompanied by an increase in the reimbursement rates. As mentioned in other groups, the consumers without health insurance would also like to see VHAP adopt a sliding scale policy for participants at the upper-limits of the income eligibility scale. Respondents suggested allowing VHAP participants "ease-off" the plan, by paying premiums, co-pays and deductibles in accordance with their income. This would allow VHAP participants to accept raises and/or higher paying jobs without losing their health insurance. For some it would also allow participants who do not have access to health insurance to participate.

In both focus groups with uninsured Vermonters, participants mentioned concerns about the amount of "red tape" and paperwork required for enrolling in VHAP. Participants in both groups also mentioned that they had heard that the state was planning to discontinue the VHAP program this coming October.

c. VHAP Buy-In to Employer-Sponsored Plans

Consumers without health insurance had very similar reactions to the VHAP Buy-In coverage options as did participants in the employer groups. Initially, they liked the idea, however they expressed significant concern over the differences in benefits between Dr. Dynasaur and employer-sponsored plans. They were also concerned about the possibility that parents would not be able to choose whether to keep their children on Dr. Dynasaur or move them to a private plan.

Participants liked the idea that families would be covered under one plan and they felt that covering a spouse at no additional charge was a great benefit of this policy option. Most agree that the VHAP Buy-In would only be an acceptable policy option if the private insurer offered a similar level of benefit for the insured.

Both groups of uninsured Vermonters expressed concern that, under this policy option, the state would "force" people to purchase individual plans, even if a parent currently chooses not to be insured. Participants asked whether children would be denied coverage under Dr. Dynasaur if one of their parents had access to employer-sponsored health insurance, but choose not to enroll in the plan. It was noted that many people who have their children on Dr. Dynasaur choose not to accept employer-sponsored health insurance because of the cost. Others mention that a parent may choose not to accept an employer-sponsored plan because of the quality of the coverage being offered or because they do not want to do business with that insurer.

Participants wondered what effect this policy option would have on employers. However, in one group, participants thought this plan would be beneficial to employers, allowing them to have more insured people in their group and, therefore, to be able to bargain for better rates.

Similar to participants in the employer groups, participants were concerned about what would happen to children whose parents did not have access to employer-sponsored insurance. Would they be uninsured? Others questioned what would happen if a parent chose to take advantage of this policy and then was laid off. Would it be difficult for them to get their children re-enrolled in Dr. Dynasaur?

Overall, participants agree, with a few reservations, that the VHAP Buy-In to Employer-Sponsored Plans is a good idea. Most agree that people should not be forced to participate. Most also think that coverage under Dr. Dynasaur should be an option for anyone who found themselves laid off from their job or if the costs increased and the family could no longer afford their contribution to the employer plan.

d. Employer Health Insurance Tax Credit

The final two options, the Employer Health Insurance Tax Credit and the Low-Cost Insurance plan were discussed briefly in the uninsured groups. Many of the participants found it difficult to switch gears from evaluating individual-targeted plans to evaluating employer-targeted plans. A number of participants simply found it difficult to evaluate the employer plans because they are not employers. Generally, participants agreed that the tax credit would be a good plan and would act as an incentive to employers to offer health insurance.

Uninsured participants did see many of the same drawbacks mentioned by participants in the employer groups. Most agreed that only offering the tax incentive to employers who have not been offering insurance is not fair to those who have been trying to help their employees. Participants also believe that the average wage requirements encourage employers to continue paying low wages so that they can qualify for assistance plans.

Some participants wanted to know how it would be determined if a company would receive a 25 percent reimbursement or a 40 percent reimbursement. One group suggested that the amount of the tax credit be correlated to the company's profitability, so that the least profitable companies would see the greatest benefit from this plan.

e. Low-Cost Insurance Plan

Consumers without health insurance appreciated the Low-Cost Insurance Plan for the fact that the state was offering to help employers afford health insurance and because it would be available to companies with 50 or fewer employers. However, overall, these participants did not feel very positive toward this policy option.

Similar to the other focus group participants, the uninsured participants criticized this policy option because of the benefit exclusions. They found the benefit exclusions to be limiting and, therefore, perceive the plan to be less beneficial to the policyholder than other commercial plans would be.

Participants also expressed concern about the requirement that half of a company's employees must enroll in the plan. Some wondered if people who can not afford to pay the employee

portion of an employer's health insurance plan would be pressured into enrolling in a plan so that the whole company would be eligible.

Overall, the consumers without health insurance did not think that the Low-Cost Insurance Plan would be a significant incentive to get an employer to begin to offer health insurance. First, the uninsured saw that a 15 percent-20 percent savings in the cost of the premium is not significant enough of an incentive to get an employer to offer such a plan.

Secondly, they thought that the average wage earned requirement would encourage employers to continue to pay low wages.

f. Evaluating the Coverage Options

Consumers without health insurance ranked the Direct Care Model and the Medicaid Eligibility Expansion highest of the three plans that they discussed in detail. Both of the plans were ranked highest because they were perceived to offer the most benefit to the most people.

Personalization of health insurance was an issue that contributed to the difficulty that many participants had in evaluating the policies. When evaluating a plan, participants often experienced significant confusion over the details of the plan. A large part of the time spent discussing each policy option was spent explaining details and clearing up misconceptions based on participants' reading of the policy. Often participants did not see how a particular plan would relate to their personal situation, and, therefore, did not know how to react to the plan. At times, respondents were able to step back and evaluate the options based on broader considerations, but it is important to note that they were mostly evaluating the plans based on their personal situations.

g. Summary and Recommendations

In combining the recommendations for expanding coverage from the first focus groups with the results of the market testing, considerable consistency was noted between the initial recommendations and the coverage options that were developed. ***Figure 84*** contains a summary of the recommendations of uninsured individuals, the options that relate to each, and the evaluation of the various options.

Figure 84
Summary of Recommendations by Uninsured Individuals

Recommendation	Coverage Option	Evaluation	Quote
Expand eligibility limits on existing state-funded health insurance plans	VHAP Expansion to 300 percent of Poverty	*Pros* ✍ Targets most needy people ✍ Builds on existing plans ✍ Could have sliding scale pay *Cons* ✍ Doctors won't take it ✍ Red tape, paperwork	"There should be a soft outer limit for where income eligibility ends because people want to take that job and earn a little more money, but don't want to be penalized by losing all the benefits."
Insured should offer incentive to those who do not utilize the health care system often	None		
Be able to tailor their plan to their needs	Direct Care Model	*Pros* ✍ Sliding scale ✍ Option exists now *Cons* ✍ Point of access not clear ✍ Income requirements confusing ✍ Depends on docs' participation	"The sliding scale fee is probably the best thing about it. It gives everybody an option to be able to get access to some kind of medical care regardless of how much money they have or don't have."
Employers offer health insurance to part-time and seasonal employees	Employer Tax Credit	*Pros* ✍ Incentive to employers *Cons* ✍ Not fair to firms already offering insurance ✍ Wage requirements encourage low wages	"This would probably encourage more employees to take out the extra family plan, since they are going to get help. That, in turn will help the employer because the more people he insures, the cheaper the policies are."
	Low Cost Insurance Plan	Pros ✍ Small insurers helped Cons ✍ Not significant enough incentive for employers	"It tells more of what it excludes than of what it includes. It seems like it leaves out a lot."
	VHAP Buy-in	*Pros* ✍ Encourage firms to offer family plan ✍ Costs the state less *Cons* ✍ Might not have equal benefits as Dr. Dynasaur	"This would be okay if it were optional. But if a parent can't afford the payment for individual insurance, their kid should still be able to get Dr. Dynasaur separately."
Educate people about plans that already exist	Outreach	None	"Publicity is an issue. This is about services that are already offered. The fact is a sliding scale does already exist. However, you are required to seek it out."

2. Market Testing with Employers

Several focus group sessions were conducted with employers throughout the state. Most groups found the policy options difficult to digest and understand. Both employers and consumers had many questions about each plan. In most groups, participants indicated at some point that they did not feel that any of the options addressed what they believe are the core issues in insuring more Vermonters - affordable health care and affordable health insurance.

In nearly every group, participants raised concerns regarding eligibility requirements for participation in the plan. Participants did not like the idea of targeted, or, from their perspective, limited, assistance. Many groups wanted to discuss "affordable health insurance for all Vermonters." Whether it was the idea of tax credits for employers who have not been offering insurance or sliding-scale fees available to the uninsured, participants felt that all Vermonters were entitled to relief from the high costs of health care and health insurance.

a. Employer Health Insurance Tax Credits

This plan was presented as one that would give a refundable tax credit to small employers of low-wage workers who begin offering health insurance to their employees.

Employers are very attracted to the idea of getting tax relief in exchange for offering health insurance to employees. A number of participants agreed that this policy option would encourage more employers to offer health insurance to employees. Additionally, some employers noted they appreciate that this plan allows employers the freedom to choose which plan they would like to offer.

Some also noted that they would like to see the amount of the credit increased to 40 percent-60 percent of employer costs. Consumers without health insurance suggested that the amount of reimbursement be tied to a company's profitability, so that the least profitable companies would see the largest proportional reimbursement.

Employers who are already offering health insurance to employees were upset by the eligibility requirement that would prohibit them from taking advantage of this policy. Participants in other groups also felt this requirement was not fair. Most groups recognize that affordable health insurance is a problem for most small businesses, not just those that do not offer insurance.

Participants also recognize that, although this policy option would help, many employers cannot afford the cash output required to pay the premiums on a monthly basis. These participants noted that the Employer Health Insurance Tax Credit does not address the need for more affordable health insurance premiums in Vermont. A few also noted that this policy does not address the fact that many low-wage workers cannot afford to pay their share of the premium required to join an employer-sponsored plan.

Many thought that requiring the firms' average wages to be below the statewide average would be limiting to many businesses. Employers cited the fact that in today's economy, they have had to raise their wages to be competitive. Others noted that their particular industry or location (such

as Chittenden County) required them to pay higher-than-average wages and, therefore, they would not be eligible.

b. Low-Cost Insurance Plan

This plan was described as an insurance policy that would cost 15 percent to 20 percent less than other commercial plans. The plan would exclude state-mandated benefits and the state would offer a reinsurance program for 90 percent of benefit payments in excess of $30,000.

This policy option was widely considered a good plan for those who do not have any other choices. Overall, it was viewed as a moderately adequate solution to the health insurance problem facing employers. Many liked the idea that a low-cost plan would be available; however, contrary to early findings, most felt the excluded benefits were a major drawback to this plan.

Respondents agreed that in earlier focus groups they championed the idea of being able to purchase a plan free of state-mandated benefits. The difference between what they described earlier and the Low-Cost Insurance Plan was that this plan did not address the deregulation of the insurance industry, which they believed would increase competition and lower prices.

Some participants indicated that they were not aware that benefits such as home health care and drug and alcohol treatment were state-mandated benefits – and they felt insurance plans should cover those services. Others noted that many people utilize chiropractic and mental health services. Some agreed that the benefits exclusions were an acceptable way to achieve "cheap" health insurance coverage; however, most agreed they would not want to be covered by such a plan.

Many participants agreed that a 15 percent to 20 percent savings would not be enough to justify purchasing a plan with significantly fewer benefits than other plans. It was noted that a 15 percent to 20 percent price reduction would barely cover a single year premium increase at the rate that health insurance companies have been raising premium rates.

Every group was significantly confused by the reinsurance portion of this policy option. Many thought that it meant the employers had to pay out $30,000 in health insurance expenses before the plan would begin to assist them; others thought that the employer would be responsible for paying the first $30,000 in benefit payments.

Respondents also criticized participation requirements. They believed that the employee income caps were too low; that some employers of low-wage workers would not be able to afford half of the premium, and that it would be difficult to get half of the employees in low-wage firms to agree to sign up for the plan. Most also agreed that a $100,000 lifetime benefit cap was too low.

c. VHAP Buy-In to Employer-Sponsored Plans

This plan was described as one that would shift children from Dr. Dynasaur to a parent's employer-sponsored health plan. This would be done only in instances where it would be less

costly to the state to pay the difference necessary to obtain family coverage on the private plan than to keep the child enrolled in Dr. Dynasaur.

Initial reactions to this policy option were good. Participants liked the idea that the plan would save the state money and that it would assist individuals in affording private insurance. Many appreciated the individual-targeted approach.

However, participants noted that Dr. Dynasaur benefits are often far superior to benefits available in an employer-sponsored plan. They also mentioned that the policy option would increase costs to individuals, because most employer plans have co-pays and deductibles, which individuals were not paying under Dr. Dynasaur. Participants looked significantly less favorably on the plan when they realized that, although the state would save money, individuals would end up with more out-of-pocket medical expenses.

Participants were concerned that many parents would be unwilling to move their children from Dr. Dynasaur to an employer's plan. Questions were raised about whether people would be required to move their children, against their wishes. Many also wondered what would happen in cases where a parent is offered insurance, but chooses not to be insured for cost reasons. Would that person be required to pay the individual premium portion, so the state could shift the children to the employer plan?

There were also concerns about the state's involvement in the administration of this plan. Most agreed they did not want the state making decisions about who should be on which insurance program. Many also anticipated a significant amount of bureaucracy and paperwork, requiring many administrative personnel. Many questioned whether the state had the current capacity for this additional work.

Questions were raised regarding whether shifting a number of children from Dr. Dynasaur to private insurance would increase health insurance premiums for all. Many thought that this would be the case. However, consumer without insurance believed that adding more people to private insurance policies would give employers more bargaining power to get lower premium rates.

As with other policy options, many note that this plan does little to address the need for lower premium costs or more affordable health care. They also criticize the plan for being selective about who receives assistance, noting that this plan would only help those who are already offered health insurance and would do nothing for people without access to insurance.

d. Direct Care Model

This plan was presented as one that would provide funding to expand the availability of free or subsidized health care for the uninsured.

This policy option was perhaps the most confusing to nearly all of the groups. Many could not understand that this was not a health insurance program, nor could they understand how this program would work. Many were cynical about a doctor's or a hospital's willingness to

participate in another program that did not charge full fees for services. Participants used Medicaid and Medicare as examples and insisted that there would be no such thing as free care.

Consumers without health insurance were not as confused by this policy option. They were slightly less cynical about doctors' and hospitals' willingness to participate in such a system. Despite this, they had many of the same questions and concerns as those in other groups had.

Participants believed that someone, somewhere, would end up paying for the care delivered under this model. Most believed the burden would fall upon taxpayers and insured people in the form of higher taxes and higher premium rates.

The perception is that doctors are already overbooked, because many people have difficulty getting in for appointments. Therefore, many questioned how doctors would be able to fit in new patients from this plan. Many also believe that doctors are reluctant to take Medicare and Medicaid patients, because of low reimbursement rates. Given this, they question a physician's willingness to take on more patients who would not be paying full cost for their services.

Additionally, many believe that this option is targeted toward a group of people who are most likely already eligible for other types of assistance. Participants also mentioned that this program does not address the issue of affordable health insurance and care for all Vermonters.

Despite the confusion over this model, many did praise it for getting people access to health care and helping them afford it. Many agreed that the plan would reduce the cost of caring for the uninsured by integrating them into mainstream care, getting access to preventive care and reducing the need for emergency room visits.

e. Medicaid Eligibility Expansion

This plan was presented as one that would expand the income eligibility levels for VHAP to 300 percent of the federal poverty level for all Vermonters. The increase would be implemented gradually.

Many thought that this policy option was a good idea. They see that this policy option would achieve the goal of insuring more Vermonters, specifically addressing the needs of uninsured adults in Vermont. Many preferred this plan because it targeted individuals rather than employers. This plan was also seen as one that would address the need of Vermonters who work multiple part-time jobs or hold seasonal positions and, therefore, are not eligible for employer-sponsored health insurance.

Again, participants took issue with some of the eligibility requirements. A few felt that 300 percent of the FPL was too high; however, most felt that 300 percent did not go far enough. Many thought that the eligibility levels should be increased at the same time for everyone, regardless of whether or not they have children.

One concern voiced about this policy option is whether it would cause more people to drop employer-sponsored coverage, thus making it more difficult for employers to qualify for plans or to afford the premiums. Another concern is that this option will end up costing taxpayers more.

Uninsured respondents and one group of employers who do not offer health insurance note that expansion of VHAP will increase the cost shifting that occurs due to the reimbursement rates.

Participants did mention they would like to see a gradual move off VHAP, rather than a strict cutoff. Respondents thought that those over 300 percent of the FPL should be allowed to participate in VHAP, but pay premium payments, deductible and co-pays. They envision that these payments would increase the higher one's income level was.

f. Comparing the Options

Each group was asked to rank the three policy options they evaluated in depth. Participants from businesses not currently offering insurance named the Employer Health Insurance Tax Credit as their first choice and the Low-Cost Insurance Plan as their second choice. The VHAP Buy-In was the third choice.

Employers who are offering health insurance to employees were most likely to select the VHAP Buy-In to Employer-Sponsored Plans as their first choice. The second choice was the Employer Health Insurance Tax Credit and the lowest-ranked plan was the Low-Cost Insurance Plan.

Generally, employers gave the highest ratings to the plans that they felt would benefit them most directly. In fact, many employers who do offer health insurance noted that they did not really prefer any of the plans, because none were targeted toward them and their struggles with offering health insurance.

The consumers who have health insurance had very different opinions on which of the individual-targeted plans rated first. In Rutland, respondents named the VHAP Buy-In as their first choice; in Bennington, respondents preferred Medicaid Eligibility Expansion. Consumers without health insurance ranked the Direct Care Model and Medicaid Eligibility Expansion as their first choice.

Near the end of each group, respondents were asked to vote on all five plans that had been presented and discussed. Two out of three indicated they would support the Employer Health Insurance Tax Credit and Medicaid Eligibility Expansion. Half supported the idea of the VHAP Buy-In to Employer-Sponsored Plans or the Direct Care Model. About one in three supported the creation of a Low-Cost Insurance Plan.

Perhaps not surprisingly, employers who do not offer health insurance are most likely to support the programs targeted toward employers not currently offering insurance (Employer Health Insurance Tax Credit and Low-Cost Insurance Plan). Employers who do currently offer health insurance prefer the individual-targeted plans (Direct Care Model and Medicaid Eligibility Expansion). Interestingly, consumers who have health insurance spread their support among the Employer Health Insurance Tax Credit, the VHAP Buy-In and the Medicaid Eligibility Expansion; those without health insurance supported all of the plans except the Low-Cost Insurance Plan.

L. Policy Recommendations of the Steering Committee

This section summarizes the recommendations made by the steering committee based upon the evaluation of the policy options discussed above. It is important to note that Vermont has had considerable success in increasing access to health coverage over the last decade. Coverage expansions are difficult to achieve without concomitant federal support or action. Particularly in the current economic climate, States cannot do it alone. Many of the populations that could be reached with available federal policy options have already been covered. It was evident based on the analyses performed for the Steering Committee that no single strategy, other than a tax financed system, was available to reach all of the 8.4 percent uninsured in Vermont. Increases in the level of coverage considered by the Steering Committee to represent reasonable interim coverage goals were to:

? Provide coverage for 95 percent of Vermont adults

? Provide coverage for 97.5 percent of Vermont children

A major finding is that the remaining hard-to-reach cases are part of a diverse group of individuals, ranging from the 36 percent of uninsured who are eligible for public programs and not enrolled to those working adults who reject employer-sponsored health insurance. As such, recommendations from this project address the varying pockets of uninsured individuals with incremental solutions rather than a single policy initiative.

As discussed above, for each option considered by the Project Team and Steering Committee, Lewin estimated the number of people who would become insured and the cost of subsidies provided under the program. This includes estimates of the cost to the State and costs to the federal government under policies where federal matching funds are available. All of the options considered by the Steering Committee would result in a reduction in the number of uninsured. Aside from the single-payer model, the option having the greatest potential impact on coverage were outreach programs to enroll people who are already eligible for Medicaid, VHAP or Dr. Dynasaur who have not yet enrolled. However, the capacity of the VHAP program to serve additional enrollees and receive federal funds in constrained based upon the budget neutrality provisions of the 115a waiver.

Findings from the project analysis resulted in the conclusion that higher levels of coverage could only be achieved by combining the various policy options. For example, if the state 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 97.4 percent of children and about 93.6 percent of adults would be insured. Adding the VHAP program would increase coverage for adults to 94.5 percent.

Similarly, a combination of the options designed to expand private insurance coverage would also raise coverage levels. For example, providing the employer tax credit (40 percent credit for firms with under 25 workers). However, coverage would reach only 96.7 percent among children and 91.1 percent among adults.

Given favorable economic conditions, implementing the full range of VHAP expansion and buy-in options, together with the employer tax credit and the low cost insurance product would reduce the number of uninsured by about 22,200 people, which is equal to about 43 percent of Vermont's uninsured population. Coverage under this combined policy would reach or exceed the defined targets: 98.0 percent among children and 94.7 percent among adults.

The policy recommendations of the Steering Committee are presented below.

1. *In the short term Vermont should direct resources toward maintaining existing levels of coverage*

In Vermont, approximately 91.6 percent of all people have insurance coverage from some source. About 95.8 percent of children are covered and about 90.2 percent of adults are covered. Given the bleak short-term economic forecast, Vermont should focus its efforts toward maintaining this existing level of coverage.

2. *The target goal of 97.5 percent coverage of children can be met without new program initiatives. The Agency of Human Services should continue current outreach initiatives to eligible children not enrolled in Dr. Dynasaur*

The State could achieve the interim enrollment goal for children by increasing enrollment in existing programs, especially Dr. Dynasaur. Vermont has already implemented a number of initiatives to increase enrollment of children, including media campaigns and outreach through schools, providers and other groups. Outreach programs that are being conducted in schools and with employers could be expanded. The State should carefully consider any further changes in premiums. Research indicates that participation is reduced by about one-third in cases where a premium is required, even where the premium is as low as $10 per month.

3. *Coverage should be expanded incrementally based on the State's financial capacity*

The Steering Committee's analyses identified that multiple incremental strategies will be necessary to make health insurance available to everyone. State initiative should focus on uninsured Vermonters at or below 300 percent of the federal poverty level (FPL). As noted above, statewide coverage targets for Vermont are defined as 95 percent of adults and 97.5 percent of children and could only be reached through a multifaceted approach and a robust economy.

The specific recommended initiatives described in detail in Section 4 of this report are:

? ***VHAP Buy-In*:** The VHAP program could be used to provide a lower cost coverage alternative for individuals and employers. For example, individuals without access to employer coverage living below 300 percent of the FPL could be permitted to purchase coverage under the VHAP program by paying a premium. Similarly, small employers 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 the same as those provided under the current VHAP program. However, buy-in participants would be required to pay a

premium equal to the full cost of their coverage (i.e., average cost per enrollee). Although participants would be required to pay the full premium for coverage, it is still likely to be a lower than the cost of purchasing comparable coverage in the private sector. This is because provider payment levels under the VHAP program are generally substantially lower than payments rates under private plans. In addition, administrative costs under VHAP are generally lower than in private plans because there are no commission payments to brokers and agents, and there is no allowance for insurer profits. Adjustments of provider payment rates to Medicare levels would be made under this option.

? ***Incrementally Expand VHAP up to 300 Percent of Federal Poverty Level*:** Income eligibility levels for the VHAP program would be increased incrementally to 300 percent of the Federal Poverty Level (FPL) for all Vermont residents. This corresponds to annual income of roughly $25,000 for a single individual and $53,000 for a family of four. Because children through 300 percent of the FPL are already covered under Dr. Dynasaur, this would affect primarily adults between the current VHAP eligibility level and 300 percent of the FPL. (The current VHAP eligibility is 185 percent of the FPL for parents living with children; and 150 percent of the FPL for adults without children.) The expansion would be implemented gradually. For instance, the expansion might begin by increasing eligibility levels for parents living with children to 200 percent of the FPL, then gradually increasing to 250 percent, etc. Then consideration could be given to expanding eligibility for adults without children.

? ***Create a Small Employer Tax Credit***: An approach to expanding coverage would be to provide subsidies directly to employers to help them provide coverage to their workers. This could be accomplished through a refundable tax credit to employers who are not now providing coverage. Existing proposals for an employer tax credit would set the amount of the tax credit equal to a percentage of the of the employer's expenditures for employee health benefits (e.g., 25 to 40 percent).

Eligibility would be limited to: (1) firms that have not provided coverage for at least 12 months; and (2) firms with an average payroll below the average for small firms in the state. These firms would receive these tax credits for a period of three to five years as long as the firm continues to meet the firm size and average payroll eligibility criteria. The dollar amount of the credit could also be phased-out with percentage reductions each year over the three to five year period.

Options are available to vary the credit by amount and firm size:

? Firms with 10 or fewer workers - 25 percent credit;

? Firms with 10 or fewer workers - 40 percent credit;

? Firms with 25 or fewer workers - 25 percent credit;

? Firms with 25 or fewer workers - 40 percent credit.

In addition, the following two models were discussed in some detail by the Steering Committee during their deliberations. The Direct Care Model offers an interim, but important safety net for

Vermonters without health insurance and who are not eligible for existing programs. It differs form other strategies in that it is not insurance coverage, but offers the direct provision of basis health services. The single-payer system also differs in that it represent a fundamental restructuring of health care financing, moving from a mix of public and private financing to a universal, tax based financing system. It has significant implications for the private insurance market, current insurance and coverage arrangements, and offers the guarantee of universal coverage for all Vermont residents. A summary of the perspective of the Steering Committee on these two approaches is discussed below.

The Direct Care Model

The Steering Committee recommended that the direct care model be supported and resources provided to foster this approach. Vermont currently has a number of avenues for uninsured individuals to receive health care in the community. Vermont has a system of traditional and integrated free clinics, and Federally Qualified Health Centers (FQHCs). Several sites of well-organized, integrated free clinic direct care programs exist in Vermont. The Gifford Medical Center in Randolph, Mt. Ascutney Hospital and Health Center in Windsor, and Fletcher Allen Health Care in Burlington run excellent examples of the direct care model, with other hospitals considering this approach. Although these programs do not provide "health care insurance coverage" as traditionally understood, they provide an important source of care for many individuals that is often the preferred source of care for some of the participants of these programs. One compelling characteristic of the Direct Care Model is that it is locally based and thus can be tailored to the needs of the patients and providers in each community, and represent a modest investment at the state and local level.

The FQHCs provide comprehensive community based primary care. The feature of the FQHCs that is particularly important in relation to the Direct Care Model is that they provide care on a sliding fee schedule basis for uninsured individuals, and as such serve as a safety net for these individuals. There are five FQHC sites in Vermont.

The recommendation of the Steering Committee is to both support and expand this effort where possible, and to provide such support as is necessary to foster the evolution of this service model. The Steering Committee did not see this as a long term substitute for insurance coverage for all Vermonters, but one that can provide necessary care that builds upon an existing structure and will possibly bring Federal or other non-State revenue into Vermont.

The Single-Payer Model

The Lewin Group prepared an analysis of the single-payer model for the Steering Committee. This model is not an incremental approach to covering the remaining uninsured using the existing public and private insurance systems operating in Vermont. Rather it would fundamentally alter the financing of health services in the State. It is the only approach considered that would achieve universal access and as such had strong proponents within the Steering Committee process. Likewise, it also would require a public commitment to a tax financed system and would have significant implications for the private insurance market, businesses that both provide employee health benefits and those that do not, and individuals. These implications were of concern to opponents of this approach. The single-payer did not have

sufficient support from the Steering Committee members to include it among the approaches that were "field/market tested" during the State Planning Grant process. The analysis performed by the Lewin Group details the changes and potential impacts of this model. The full report on the single-payer model is included in the appendix to this report.

SECTION FIVE: CONSENSUS BUILDING STRATEGY

The Steering Committee included representatives of various State agencies and private organizations. All of these representatives worked together on the development of coverage options within Vermont. This section summarizes the process used both to achieve collaboration among stakeholders as well as achieve consensus on the policy options selected.

A. Compilation of HRSA- Related Activities

Because the Steering Committee members represented a diverse group of stakeholders and were involved with health policy and other groups, one of the early activities in the process was to identify other groups and projects related to our work. It was felt that the HRSA project could benefit from the findings of these other groups, and that the "whole was greater than the sum of the parts." These activities are described below.

1. Governor's Commission on Health Care Availability and Affordability.

This bipartisan group was charged by Governor Howard Dean in his 2001 State of the State Address to "study data and travel the state talking to employers and others concerned with rising health care costs to find ways to achieve the dual goals of controlling costs and guaranteeing universal access. Their task was to lay the groundwork so that the Legislature and the people of Vermont can begin to reach consensus on how to proceed." Specifically, this commission:

? Studied data and information relative to (i) increasing health care costs, (ii) cost shift, and (iii) availability of services;

? Talked with employers and others concerned with rising health care costs and access to health care;

? Identified ways to achieve the dual goals of controlling costs and guarantee universal health care access; and

? Reported to the legislature and the Governor on the Commission's findings and lay out recommended approaches to address these problems.

The Bipartisan Commission on Health Care Availability and Affordability will issue its final report on or about November 10, 2001.

2. Commission on the Public's Health Care Values and Priorities (PHCV&P)

The Commission was formed to provide a mechanism for continuing public discussion and input regarding Vermont's health care system, creating and using a long-lasting model for citizen dialogue.

The goals of the commission are:

? Have a public that is better informed on health care issues and information.

? Determine the public's values related to societal access to health care.

? Determine the public's priorities and preferences for how to provide societal access to an appropriate level of health care.

Current activities of this Commission include a random digit dial survey of Vermonters to identify their health choices. Support from the Agency of Human Services will allow this Commission to expand the scope of the survey, compare the results with a similar survey done 5 years prior to see if Vermonters values, priorities and choices, values and priorities related to health care have changed and how, and to report to the State Planning Grant Steering Committee.

3. Vermont Ethics Network (VEN)

VEN received a grant from the Study Circles Fund (Topsfield Foundation) to develop and conduct a series of weekly "study circles" for 40 regional study groups of 8-12 participants each to discuss Access to Health Care in Vermont. VEN then partnered with the Commission on the Public's Health Care Values and Priorities for the purpose of distributing PHCV&P questionnaires to study circles participants in order to compare and contrast the health choices between self-selected individuals (participants in the study circles) and those randomly chosen for the telephone survey. Facilitators for the study circles were trained in September and some circles have started. While a few circles will take place during the Fall, the project's kick off day and press conference scheduled for September 11, 2001 were rescheduled for mid-January 2002. A final report is projected in March 2002.

4. *Vermont Business Roundtable*

The Vermont Business Roundtable is creating an employer guide to controlling health care costs through benefit plan design and use of corporate wellness programs. This guide will provide models of successful programs from within Vermont and from other markets. These models will include incentives for positive personal health behavior, emphasize wellness and prevention, and encourage effective utilization of health services and the control of health care costs.

This guide will provide guidance and information on benefit design options including: an assessment of employer considerations when purchasing a health plan; a summary of cost benefit design options; and benefit design models that include wellness and health promotion.

The desired outcomes of this project include better informed employers, healthier and more productive workforces, increased awareness of personal responsibility, and more effective control of overall benefit and health care costs. This project will be completed in the winter of 2002.

5. The Vermont Coalition of Clinics for the Uninsured (VCCU)

The Vermont Coalition of Clinics for the Uninsured (VCCU) is a group of free medical care clinics (and one dental clinic) in Vermont which work together to provide a safety net of primary care services to individuals whose household incomes fall below 200% of the federal poverty

level and who either lack health insurance entirely or are under-insured (e.g., high deductibles). The nine member clinics are distributed around the state and although each has its own board of directors, maintains its own policies, and does its own fund-raising, some funding from the State of Vermont and private foundations comes through the coalition. In addition to providing direct primary care at no or minimal cost, the coalition actively advocates for its constituents.

There are two different models of clinics in the coalition. The majority of the clinics operate as "traditional" freestanding facilities, staffed by volunteers; these clinics offer services to the uninsured through occasional (weekly to tri-weekly) clinic evenings. Several of the formerly traditional clinics now operate as an "incorporation" model. Rather than providing a separate set of services for the indigent, these clinics operate through local hospitals and medical care practices to incorporate their clients into the mainstream provision of health care services.

The VCCU is researching differences between the two models with respect to the following issues:

? Socio-demographic characteristics (e.g., age, gender, income, family structure) of the client population;

? Medical/health status (e.g., presenting medical condition, necessary referrals) of the client population;

? Numbers of clients served as a percentage of the uninsured in the catchment area;

? The range and accessibility of services provided;

? The cost per client served; and

? Selected measures of client outcomes.

6. Vermont Department of Health

? Behavioral Risk Factor Surveillance Survey: On-going telephone survey of approximately 4200 Vermonters annually. Includes questions of health insurance, use of health services, health status and risk factors.

? Health Care Provider Survey: Biennial survey of physicians, nurse practitioners, physician assistants and dentists. Includes demographics, specialty, hours worked, practice location, practice characteristics and other items. Registered and licensed nurses added in 2001.

? Federal Designations of Underservice: Analyze service areas, request new or renewed designations for primary care, mental health and dental health. Also recommend Governors Designations.

? Loan Repayment Program: Payments on behalf of primary care providers, psychiatrists and dentists to cover part of outstanding educational loans in return for commitment to practice in

underserved and rural areas. Administered by the Area Health Education Centers and linked to Freeman Foundation Award program.

? Critical Access Hospital Program: Special designation of small community hospitals to improve financial stability. A component of the Rural Hospital Flexibility Program.

? Grants to Vermont providers to support access initiatives: Coalition of Clinics for the Uninsured, Burlington Community Health Center, and Vermont Recruitment Center.

? Personal assistance: Enrollees in VDH programs (WIC, CSHN, HIV, etc.) receive assistance with applying for and using health insurance.

? Development and distribution of practice guidelines: Reportable infectious diseases, immunization, diabetes, lead screening, child periodicity schedule, adult clinical preventive services.

? Healthy Vermonters 2010: Outcome objectives and measures related to health status, access to health services and risk factors.

? Vermont Health Plan 1999: Long term goals for improved health focusing on the major determinants of health: biology, socio-economic status, health behaviors, the environment and the health care system.

? Rural Hospital Flexibility Program: Grants and technical assistance to community hospitals and others to improve networking, emergency services and the quality of health care.

7. Covering Kids

Vermont began work in September 1999 with grant funding from the Robert Wood Johnson Foundation. Each state has some version of this program. Its purpose is to take whatever steps may be necessary to reduce the number of uninsured children in the state – with particular attention to those children eligible, but not enrolled, in Dr. Dynasaur. The program is a public-private partnership, managed by representatives of several agencies of state government, and several private-sector organizations. While much of the initial effort was focused on understanding which children were uninsured, and how they might be better reached, the program also focuses its effort on outreach, and simplification of the enrollment processes. A key component of the program is the work of the 12 regional partnerships throughout the state. With funds made available from the grant, these partnerships have touched bases with a multitude of community organizations, agencies, and individuals to enlist their aid in the program's efforts. The initial grant period for the program is three years. However, the Foundation has recently announced its intention to extend the program for four more years, expanding it with a new title: "Covering Kids and Families".

B. Steering Committee Composition and Communicating with Other Groups

The Steering Committee was comprised of representatives from a variety of constituent groups, including 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 State Ombudsman's Office; the Vermont Department of Health; BlueCross BlueShield of Vermont; the Agency of Human Services Department of Prevention, Assistance, Transition and Health Access (PATH); and the Veteran's Administration Hospital. And Regional Medical Center.

The Steering Committee met monthly, with meetings open to the public. Any interested people were put on the Steering Committee meeting notice email list to receive copies of minutes and notices about meetings. A link to all reports generated was established on the PATH web page.

Many Steering Committee members also serve on other committees and commissions, and thus were able to bring information from and give regular updates to their respective constituent groups. Several members regularly attended meetings of the Bipartisan Commission on Health Care Availability and Affordability, and the legislative Health Access Oversight Committee. In addition, through the Steering Committee, The Lewin Group made several formal presentations to these two groups. In addition, the Lewin Group formed a work group of insurers and providers to obtain their perspectives. The results of these groups are summarized in ***Appendix A*** and ***Appendix B***.

C. Understanding Coverage Options

Reports from the qualitative research as well as an array of coverage policies and options were discussed in the initial meetings of the Steering Committee. In order to begin the process of systematically examining the options and finding consensus among the diverse groups represented by members of the Steering Committee, a conceptual framework was presented at the March meeting. Four broad coverage option types (or "buckets") were described in which to place the various options: Public program expansion models, private sector expansion models, a single-payer model, and the clinic models (not to be confused with the 'free clinics'). The Lewin Group also provided a review of approaches used in other states to expand coverage. A copy of this presentation is contained in ***Appendix C***.

Although not a coverage option but an access policy, the clinic model (later called the "direct care model") was discussed although not completely developed. It was considered by the Steering Committee to be a transitional model of direct care provision designed to provide uninsured people with continuity until a stable source of insurance or financing is available. The model consists of community-based services that are organized and implemented by local citizens and institutions to assure access to health services by all in the community. The model emphasizes primary and preventive care and provides assistance when needed to access additional care such as specialty care or pharmacy. Patients are integrated into on-going primary care and treatment systems. It is not a formal "Insurance" program, but providers agree to see clients based on local criteria and have the right to refuse to provide some services or some

individuals. There is no "out of area" coverage except as defined by referral arrangements with tertiary care centers. The “direct care model” does not replace existing insurance programs.

D. Evaluating Coverage Options

During this phase of the project, The Lewin Group evaluated the cost and coverage impacts of a wide range of options for expanding insurance coverage in Vermont. For each option, Lewin estimated the number of people who would become insured and the cost of subsidies provided under the program. This includes estimates of the cost to the State and costs to the federal government under policies where federal matching funds are available.

The Steering Committee employed an inclusive process of consideration during this phase of the project. The committee preferred to vote in favor of removing options from consideration than vote in favor of options, with the result that two models (Single-Payer and Premium Subsidies for Low Income workers) did not receive committee support for field testing. The committee, however, was reluctant to take other options off the table. Within each of eight general types of policy options, Lewin examined several variants to show the sensitivity of program costs and coverage impacts to various design parameters.

In considering options that other states had either implemented or considered, experts from those states (Kansas and New York) were brought in to report first hand on their experiences.

E. Selecting Coverage Options

The Steering Committee met for a daylong session led by an outside facilitator in order to make final selection of the options and reaffirm the coverage goals that had been implicit throughout the project. In addition to identifying strategies to make health insurance available to everyone at or below 300% of the federal poverty level (FPL), statewide coverage targets were defined as 95% of adults and 97.5% of children.

ASSUMPTIONS: To help evaluate the various options, the group developed and adopted a list of assumptions:

- Public program eligibles should be included in uninsured count
- Those eligible, but who do not enroll, require a different strategy to get them coverage
- Costs (medical care, insurance) will increase
- Available dollars will decrease
- Pressure on the uninsured will increase
- “Affordable” is subjective
- “Coverage” is subjective
- The “value” of insurance is subjective (Perceived value of insurance…)
- State revenues will deteriorate / have deteriorated

CRITERIA: The Steering Committee was then led through a process to identify and rate criteria for evaluating the options. Top criteria for rating the options included cost effectiveness, having identifiable revenue sources, increasing the number of people covered, being administratively simple, not shifting costs disproportionately, and being eligible for a Federal match. Additionally, it was felt that options should first focus on providing coverage to lower income Vermonters. A complete list of the criteria, in order of the group's support, follows:

- ? 90% Option(s) should have identifiable revenue sources
- ? 88% Option(s) must be cost effective to implement
- ? 88% Costs should not be shifted disproportionately to any entity (all must share in the cost)
- ? 83% Option(s) should increase the number of people covered
- ? 83% Eligibility for option(s) should be geared to ability to pay
- ? 81% Option(s) should be administratively simple
- ? 78% Option(s) should focus first on coverage for lower income before higher income
- ? 67% Option(s) should have Federal $ draw
- ? 64% Option(s) should increase the sense of personal responsibility
- ? 55% Option(s) must have focus group support
- ? 50% Option(s) should have quick implementation
- ? 24% Option(s) should not increase taxes

AFFINITY CHART WORK: The options were described on easel sheets and grouped into three 'families' of options and posted in different sections of the meeting room. The committee divided into three groups to identify the pros and cons of each option. The group was asked to write their "pros" for each option on warm/orange colored Post-its, and their "cons" on cool/yellow colored Post-its. The groups then rotated around the room until all had a chance to add their pros and cons to each option. The groups could, at each station, reap the benefit of seeing the pros and cons as identified by the group ahead of them.

Figure 85 contains Steering Committee member opinions on the pros and cons of each option that were defined by the groups. The group was then asked to rate the options: Outreach efforts and the Buy-in to VHAP option were rated the most highly.

Figure 85
Pros and Cons of Selected Health Insurance Expansion Options

A. Low Cost Coverage Option	
Pros	**Cons**
Employers contribute toward cost	Serious problem if needs catastrophic coverage
Relies on private system	State may end up having to pick up the tab for non-covered services
Targets employers not currently offering	People don't get care they need
Quick to implement	Substitute one kind of care for another (non-covered services)
Cost effective	Not based on good medical practice
Could get more people in system	No federal $ match
No cost shift	Lifetime benefit of $100,000 too low
Low cost per person	With information, even employees thought it was yucky
Can be time limited for employers that sign up	Creates tiered access to health care
	"Cheap" but not for me
	Very limited coverage (benefits)
	People who can least afford out-of-pocket costs may have to pay larger out-of-pocket costs
	Whittles away at gains Vermont has made in access to care
B. Employer Tax Credit Option	
Pros	**Cons**
Can be time limited for participating employees	Employers buying in small group coverage is expensive
Quick Implementation	Need larger subsidy to work
Benefit small employer can offer and become more competitive	Does not help firms who already insure employees
Supported in focus groups	Gives advantage to new firms
Focus group support	No federal $ to match
Administratively simple	Unfair to firms currently offering coverage
No cost shifted to other entities	Time limited.
Cost effective	Sign up may be slow
	Didn't work in Kansas
	Employers not able to afford initial cash outlay to offer insurance
	Too little credit
	Unclear if personal financial responsibility enhanced

C. Single-Payer Program	
Pros	**Cons**
No cost shifting	Lack of personal financial responsibility
Administratively simpler that current system	Decrease in quality
Reduced administrative hassle for providers	No clear source of revenue identified
Administrative savings at start of program	Appears to be much more costly / now person insured
Reduces business HR time spent on health care coverage	Potential ERISA court challenge
Payment not barrier to getting necessary care	Difficult to get participation by Medicare
Reimbursement same, no payer differences	No focus group support.
Everybody in same boat	No quick implementation.
More related to ability to pay	Administratively difficult
Clearer about where money comes from	Administrative savings disappear after start of program
Saves total health care costs	New cost for small business that doesn't offer insurance
Covers everyone	Could disrupt existing employment status of private insurers
	Provider payments reduced
	Lengthy start up
	Unlikely chance of enactment
	Potential negative impact on business climate
	Need to annually adjust tax rates
	Significant change for unintended consequences - economic growth - business location or relocation
	Increased public bureaucracy
	Costs maybe shifted to private coverage
D. VHAP Buy-In to Employer Coverage for Eligible Adults	
Pros	**Cons**
Returns "good risk" kids to private insurance market	Difficult to administer need.
Covers few people but would save money (a little) to spend on others	Requires a lot of cooperation from businesses
Could provide better coverage (benefits) than employer plans	Requires additional outreach to kids
Some adult spouses "automatically" added	New administration structure for small # of kids
Saves money	Targets very few of uninsured
	Private coverage frequently less comprehensive than Dr. D, Medicaid

E. Expand VHAP to 300% FPL	
Pros	**Cons**
Targets those most in need of funding	Personal responsibility unclear
Gets coverage to population that really needs it	Excludes (1 year wait for those currently insured) many who have worked hardest to take care of themselves)
Federal money for parents	Limited Federal money
Coverage cheaper than private market.	Will increase taxes
Covers more for less	High Cost
Builds on existing program	No phase-in tiers for lower income (lower income first)
Reduced amount of free care	No identifiable revenue source
Administratively more simple than private insurance	Costs may be shifted to private coverage
Aggregating purchasing power	
Brings in few more people than F	
F. Buy- in to VHAP Option	
Pros	**Cons**
Possible to do in an economic downturn	New state admin. Structures required
Cost met by premiums	Could provide incentive to maintain low wages in spite of high profit
Aggregates purchasing power	Unclear personal financial responsibility
Could allow all without coverage to buy cheaper coverage.	No identifiable revenue source
Doesn't have to be just those below 300% FPL	Costs may be shifted to private coverage
Coverage cheaper than coverage in individual or small group market	Erosion of private insurance market
Builds on existing system	
Covers fairly high number	
Increases competition between public and private sectors	
Doesn't require a public revenue source.	
Money comes from employers and employees	
Makes relative low cost option available	
No tax increase	

G. Outreach	
Pros	**Cons**
Increases in enrollment will come incrementally	Increased costs
Federal match	Provider resistance to expansion of Medicaid eligibles
Administratively simple	Upward cost shift
Cost effective	
Targets already eligible	
Meet 97.5% goal for kids	

Source: Steering Committee affinity chart work.

F. Rating the Options

When all groups had finished evaluating the options, the pros and cons were reviewed and the facilitator asked for formal recommendations. One option, the Low Cost Insurance option, was readily eliminated for not meeting any of the criteria. The group felt that there was no one option, and perhaps no combination of options when the criteria were considered, that could accomplish the goal of 97.5 percent coverage for children and 95% coverage for adults. The single-payer model would reach the most people, but even that model did not match all the criteria. The group unanimously and strongly agreed that the Low-Cost model should be removed from consideration. The options, as they were grouped and their ratings follow:

- 26% Option A: Low Cost Insurance option
- 52% Option B: Tax Credits for small firms
- 55% Option C: Single-Payer
- 55% Option D: VHAP buy in to employer coverage
- 55% Option E: VHAP Expansion
- 67% Option F: Buy in to VHAP
- 83% Option G: Outreach Efforts

Recommendations Made By the Steering Committee:

- Think in terms of where we want to progress, don't define in terms of short, mid or long term solutions
- Outreach to all
- Encourage/foster the direct care models
- VHAP Buy-In
- Employer Tax Credit
- Employer Buy-In to VHAP
- VHAP Expansion
- Ask federal government to maintain commitment
- Federal tax credit for newly insured small groups
- Adjust Federal match more equitably for Vermont
- Ask Federal government for a drug benefit for Medicare
- VT outreach expansion
- Remove Low Cost option from consideration
- Further analysis of options and related legislation
- Identify the options and the problems associated with each
- Highlight the pros and cons of the options as bulleted items in report
- Address the complexity of making recommendations (both public and private)
- Reflect in the report the risks of doing nothing
- Discuss Rights vs. Responsibilities (see Schwartz article JAMA May 15, 1991)
- Put the Direct Care model in the report and encourage its "flourishment"
- Report should reference BISHCA results to help us narrow the challenge (about 39 percent of the uninsured are eligible, but not enrolled)

SECTION SIX: LESSONS LEARNED AND RECOMMENDATIONS TO STATES

A major feature of the Vermont State Planning Grant was its emphasis on data collection. The project included a survey of households in Vermont, which provided detailed quantitative information on coverage levels across various socioeconomic groups. These data were vital in targeting eligibility under the various policy options and in estimating the cost of potential coverage expansions. The project also included a series of focus groups and expert interviews that provided guidance on how the various policy options could be tailored to best meet the needs of Vermonters.

The pace of the project was so fast that many of the lessons from this exercise probably are not yet recognized. However, the major lessons learned from this process are discussed below.

A. Importance of State Level Data

The quantitative data developed for this project was vital to the decision-making process for the Steering Committee. The data enabled us to identify the groups most in need and provided a basis for estimating the cost of various policy options. Members of the steering committee have remarked about the importance of this information. Some specific observations include:

? The Steering Committee believes that the state is unique. Using state level data reassured the group that this was adequately reflected in the development and evaluation of options.

? The data analysis showed that about 39 percent of uninsured people in the state are actually eligible for VHAP but have not enrolled. This greatly affected the group's views on what is needed in the state.

? These data also showed that, because VHAP already covers adults at comparatively high income levels (i.e., 185 percent of the FPL for parents and 150 percent of the FPL for non-custodial adults) any further expansions in eligibility for subsidized coverage would need to focus on near-poor and lower middle-income groups.

The qualitative data collected through the focus groups was less compelling than the quantitative data. However, it was useful in identifying stakeholder interests. Two important design issues were highlighted through the qualitative process including:

? Eligibility for employer-based subsidies such as an employer tax credit should not be limited to only those firms that do not offer coverage. Insuring firms should also benefit.

? Uninsured people seemed to favor the idea of employer tax credits to provide coverage to workers more than a direct subsidy to lower middle-income people to purchase non-group coverage. This appears to reflect a public preference for employer-sponsored coverage.

B. Cost Effectiveness of Quantitative vs. Qualitative Data

The quantitative data appeared to have a greater impact on the process than the focus group and interview data. In particular, the quantitative data was important to the cost analysis of policy

options, which was quite important to process. However, both the quantitative and the qualitative data were necessary to assure that the policy options addressed the areas of greatest need. Moreover, it helped identify approaches that would receive support from employers and the public in general.

The qualitative data was probably more important than generally recognized. Lewin concluded that one needs both approaches for a successful process, although it is possible that another state with more limited funds could address some of these needs with a less extensive data collection effort.

C. Data Collection Activities Not Pursued

The state collected most of the data that they had originally planned to collect through the household survey and the focus groups. However, the state did decide against doing a survey of employers primarily because of cost and the length of time required to do the survey. It was felt that the employer focus groups and interviews would be a sufficient representation of the employer community. The lack of Vermont-specific employer survey data did not emerge as a problem during the course of the project.

D. Strategies to Improve Data Collection

It is important to take advantage of the experience that states have had in conducting surveys of households concerning health insurance coverage. A number of states have conducted similar surveys and have amassed a great deal of experience that is available to other states wishing to do a survey. The data analysis experts at BISCHA found it helpful to review the questionnaires and survey techniques used in prior studies to improve the data collection effort and to avoid making similar mistakes.

Information of this type is available from the State Health Access Data Assistance Center (SHADAC). They can provide draft survey instruments and can help in survey design. The center can also assist states in designing survey procurements. This information was very useful in designing the Vermont survey. It provided some verification questions that recently have been added to existing surveys of health coverage, which have a significant impact on coverage estimates.

This is also a good source of information to use in determining sample size. This is very important to assuring that interested parties will have reasonable expectations of what the data will show. For example, sample size will greatly affect the extent to which results can be disaggregated by demographic group or by sub-state geographic regions.

E. Additional Data Collection Needs

There are five areas where additional data collection could be useful. First, the Vermont Commission on the Public's Values and Priorities will be conducting a survey to better understand the public's views on health care and health insurance coverage. Questions of this type were not included in the household survey conducted under the grant. Second, targeted

over-sampling of high-risk groups could provide a clearer picture of coverage issues for these groups. Third, information on the "value" that the uninsured place on health care and health coverage could have been helpful. Fourth, better information is needed on what employers expect from competition among insurers.

Fifth, the existing data do not provide the information needed to estimate the size of or properly identify the "underinsured" population. In many analyses, the underinsured are defined to be those experiencing out-of-pocket expenses in excess of a given percentage of income such as 5 or 10 percent. In other studies, the underinsured are defined to include people in health plans with only minimal coverage, regardless of whether they actually experience high out-of-pocket expenses.

Both of these definitions require extensive data on out-of-pocket health spending and the coverage characteristics of their health plans. The issue of how to identify and address coverage for the underinsured was raised during Steering Committee deliberations, but remains unresolved. However, the lack of this information does not seem to have significantly impeded the process.

F. Organizational or Operational Lessons Learned

The analyses performed under this grant could lead to additional outreach activities for enrollment in Medicaid, VHAP and/or the Dr. Dynasaur program. As discussed above, the household survey and data analyses indicated that 39 percent of all uninsured people in Vermont are eligible for state programs but have not enrolled.

This suggests that a substantial portion of the uninsured problem in the state could be addressed with expanded outreach efforts for children in particular. Moreover, under the current federal matching rates (63 percent regular Medicaid, 73 percent SCHIP), most of the cost of these coverage expansions could be paid for by the federal government. However, it is unclear what outreach methods would be most effective.

Another lesson from the process is the importance of access to direct services for people who do not have insurance. As discussed above, a number of hospitals in Vermont and New Hampshire have established direct care programs for uninsured people encountered in nursing rooms, with particular emphasis on those with chronic conditions. These individuals are given regular appointments with physicians in hospital owned physician practices to provide preventive care for people with chronic illnesses. The hospitals with these programs believe that these programs have greatly reduced emergency room visits. The state could take steps to encourage this approach throughout the state.

One of the key lessons learned about insurers in Vermont is some of the dynamics of competition in the industry. It became clear in this study that for insurers to offer coverage at competitive prices, there must also be substantial competition among providers. The reason for this is that insurers typically negotiate volume discounts and selective contracting arrangements with providers competing on the basis of price so that insurers can offer coverage at competitive rates.

However, selective contracting is ineffective in a market where there are few competing providers, as is the case in Vermont. For example, 12 of the 14 hospitals operating in Vermont are the only hospital within 30 miles, which effectively gives them a monopoly in the local health care market. Thus, without competition among providers, it is difficult for insurers to negotiate the agreements with providers that they need to offer coverage at more competitive prices. This finding had significant implications for the potential for increased competition in Vermont insurance markets.

The Steering Committee's interactions with the employer community were quite successful. The Steering Committee itself included representatives of two organizations representing businesses in the state. These include the Vermont Chamber of Commerce and the Vermont Business Roundtable. In addition, Lewin conducted focus groups with employers to help in defining the problems in the state, followed by a second round of focus groups to obtain employer views on suggested policy options. The process probably would have proceeded much less smoothly if the employers had not had such involvement.

G. Recommendations to Other States

As discussed above, states should take advantage of the information available from other states that have conducted similar surveys and financial analyses of health reform options. These activities can be very complex and difficult to attempt. It is important to take advantage of what was learned in these activities to avoid "reinventing the wheel" in survey design and policy analyses.

Towards the end of the project, the state engaged an independent health care expert to facilitate the Steering Committee's final meeting in which policy recommendations were selected. Introducing a fresh face at that point in the process appeared to re-energize the group and made it easier to sort through all of the various reports and policy options analyzed during the project.

Covering the last 5 to 10 percent of the population will be complex and difficult. It will also be complicated by the conflicting priorities of various stakeholders in the system. Some of these competing goals include:

? Universal access with a strong private insurance market;

? Universal access at low cost, while maintaining high quality;

? Government programs for certain groups without causing "crowd out" in the private market;

? Broad based, comprehensive coverage for everyone, but without a "single-payer" system; and

? Differing views on the role of Government.

SECTION SEVEN: FEDERAL RECOMMENDATIONS

The Steering Committee made the following recommendations to the federal government.

A. Maintain Existing Commitment of Federal Participation in 1115a Waivers that have Achieved Coverage Expansions

The Vermont Health Access Plan (VHAP) is currently operating under an 1115a Medicaid Research and Demonstration Waiver approved by the federal government in 1995. At some point in the near future, the existing waiver will need to be renewed. The success of this waiver initiative, and similar waiver initiatives in other states, is dependent on the state having sufficient state and federal resources to maintain these coverage commitments. It is recommended that the federal government (CMS) grant permanency to 1115a expansion populations by considering them part of the Medicaid spending base at the point of consideration of a new waiver, thereby eliminating the need to fund their coverage through savings under the budget neutrality provision of the 1115a waiver program. Granting permanency to these expansion populations will offer the states the best opportunity for having a sustainable program.

B. The Federal Government Should Create Additional Tax Incentives Directed at Small Employers to Encourage the Provision of Health Insurance

The most recent survey of the uninsured, as have the two other surveys done in Vermont in the 1990's, underscores that small employers are much less likely to offer health insurance than large employers. The Steering Committee recommends that the federal government use its tax authority to provide incentives to small businesses to cover their employees. An approach to expanding coverage considered by the Steering Committee was to provide subsidies directly to employers to help them provide coverage to their workers. This could be accomplished through a refundable tax credit to employers who are not now providing coverage. Existing proposals for an employer tax credit would set the amount of the tax credit equal to a percentage of the employer's expenditures for employee health benefits (e.g., 25 to 40 percent).

C. Congress Should Establish a Medicare Drug Benefit

Vermont first addressed prescription coverage for low income Medicare population in 1989 through the creation of VScript, a state funded maintenance drug program for elderly or disabled Vermonters not eligible for coverage under Medicaid. As part of the implementation of the 1115a Medicaid waiver approved by the federal government in 1995, drug coverage was expanded. Additional drug coverage is also being provided under a state-only program. Other states have similarly established state programs to provide this essential coverage. Modernization of Medicare through the creation of a drug benefit would potentially make state resources available to either maintain existing initiatives for the uninsured or finance some of the coverage options identified by the Steering Committee.