



Toward Evidence-Based Health Care Reform

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Best Intentions and Unintended Consequences

Welcome to "Toward Evidence-Based Health Care Reform," a periodic e-memo providing facts, figures, examples and analysis of current issues in health care reform in Vermont. The memo is written by Jeanne Keller, Keller & Fuller, Inc., and sponsored by BRS, Inc., a member organization providing a range of services and support to Vermont's small businesses. For more about BRS, please visit our website: [LINK](#)

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To read and download the comprehensive health care reform proposal supported by BRS and several other Vermont business associations, [click here](#).

(1) The bill requires Catamount Plan to be actuarially equivalent to state employees' PPO plan, provided thru CIGNA, and funds chronic care through the Blueprint for Health Chronic Care Initiative. The plan the state negotiated with their employees' union has no deductibles and generally \$15 co-pays for any in-network care. Out of network has \$500 deductible (\$1000 for family), 70% co-insurance to \$1000 out of pocket (\$6000 out of pocket). This plan is far more generous than what most small businesses (and more and more large businesses) are able to afford in the private market. Alternative benefit designs presented to the committee (by business associations, hospitals, medical society, Douglas Administration and the committee's own consultant, Ken Thorpe) recommended a "basic plan," something that covered basic health care needs (covering chronic care under the Blueprint initiative) and protected against catastrophic loss, and would not attract the currently insured, but the committee disregarded this advice. Because the plan's value would be set in law, in the event of cost overruns the benefits cannot be reduced by the Administration to stay within budget.

The problem doesn't stop there: the bill also restricts care management and cost management strategies that are allowed in the state employee plan. The bill includes an "Any Willing Provider" requirement, which effectively means all licensed providers, including "alternative providers" in the state can be "on network" and also limits the state's ability to negotiate discounts. (See our blog Vol. 1 No. 10 for how Any Willing Provider drives up costs.) The bill also prevents Catamount from charging different co-pays for different providers. (For example, no charging lower co-pays for higher quality and/or less costly providers, or charging a higher co-pay for unnecessary ER use) The fee schedule cannot be negotiated: fees are set in the bill at 10% above Medicare fees.

(2) The bill establishes premium subsidies based on income and family size, up to 350% of poverty. This could make half of Vermont households eligible for subsidies because the median Vermont income is BELOW 350% of poverty. (See endnote 1 for bill's income levels.) VT employers are not in a financial position to provide this level of

The House Health Care Committee's proposal, like last year's vetoed H. 524, appears to have the effect of putting Vermont on track toward a single government-operated and financed health insurance plan.

The "Catamount Health Plan," which the state will "self-insure," has numerous design elements providing significant incentives for employees to end employer-sponsored coverage, and for employers to terminate their plans and send employees to the state-subsidized, self-insured (i.e. tax funded) plan. Catamount also takes away any incentive for a non-insuring employer to start now. Considering the ruckus being raised about mega-companies like Wal-Mart not insuring their employees, it's surprising that a bill would give them a safety-net and encourage other employers to drop coverage.

To be eligible, a resident must have no access to insurance for 12-months. This appears to be an attempt to prevent leakage from employer plans, but as we describe below there are numerous legal (and even more illegal) routes for circumventing or dealing with this little roadblock. Because the committee included this waiting period, we assume their intention is to limit the subsidized Catamount Health to those who are already uninsured. However, unless the defects described below are addressed in the bill, the **committee's best intention will turn into a nightmare of unintended consequences for tax payers, not to mention a nightmare for legislators sitting in the next Biennial session.**

Why Employers Will Drop Coverage. Three elements of the bill make dropping employer coverage particularly attractive: (1) the richness of the Catamount plan, (2) the promised level of premium subsidies and (3) the fixing of maximum premiums in statute.

FAMILY SIZE	350% OF POVERTY	FAMILY SIZE	350% OF POVERTY
1	\$34,300	5	\$81,900
2	\$46,200	6	\$93,800
3	\$58,100	7	\$105,700
4	\$70,000	8	\$117,600

2. House Committee proposal for maximum premiums for individuals:

Income \leq 200 percent of FPL:	\$ 55 per month.
Income > 200 percent and \leq 225 percent of FPL:	\$100 per month.
Income > 225 percent and \leq 275 percent of FPL:	\$120 per month.
Income > 275 percent and \leq 325 percent of FPL:	\$150 per month.
Income > 325 percent and \leq 350 percent of FPL:	\$160 per month.
Income > 350 percent:	\$310 per month.

The "premiums" the state employee plan uses for the plan that is the basis for Catamount are (2-14-06):

1 person	\$444
2 persons	\$888
Family	\$1222

The House version is "richer" than the state employee plan because it includes Any Willing Provider, allows alternative providers, and does not allow differential co-pays. (e.g. if you get your primary care in an emergency room.)