Toward Evidence-Based Health Care Reform

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Assumption Junction

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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This week the VT House will vote on H. 861, "An Act Relating to Affordable Health Care for Vermonters." H. 861 contains several laudable provisions aimed at cost control, such as $2.5 million per year for The Blueprint for Health Chronic Care Initiative, but overshadowing those important efforts is the 800-pound, $66 million gorilla in the bill, called **Catamount Health Plan.** (See our last issue for more details on benefits and eligibility for the Catamount Plan.)

On the same day that the $66 million Catamount Plan was sent to the tax-writing Ways and Means Committee, members of the House Appro-priations Committee reminded them that **Vermont faces a $212 million cumulative deficit in the current Medicaid program by FY2010, under the best case scenario.** This warning did not deter the legisla-tors, who packaged an increase in the tobacco tax with an allocation of future tobacco settlement funds in order to draw down federal Medicaid "match" dollars for **Catamount Health Plan, projected to cost $132.2 million from 2007 through 2010 (state and federal dollars).** According to the committee's projections, 16,281 uninsured would be enrolled in Catamount Health by 2010, and 4,060 people would be added to Medicaid.

To understand the risk this poses, it's important to understand that Medicaid in Vermont ain't what it used to be. Late last year, the legislature approved the Douglas administration's Global Commitment (GC) with the federal government. Under this agreement, the federal government gave Vermont significant flexibility in managing Medicaid benefits and costs, in return for the state agreeing that the federal share of costs would be capped at a fixed dollar amount from 2005-2010. The total funding cap for the Medicaid Global Commitment --- state and federal --- through 2010 will be $4.7 billion. **In other words, if Vermont spends more than $4.7 billion from 2005 through 2010, the feds will NOT pay another dime. That is the Global Commitment.** "Global" doesn't mean universal, unlimited or open-ended. Global means finite. The House committees are proposing to squeeze the Catamount Health Plan in under that cap.

The GC budget is based upon assumptions that rely on significantly containing costs in Vermont's Medicaid program, just to keep the deficit lower than $212 million cumulative deficit already expected by 2010, and herein lies the rub.

- If projected Medicaid savings aren't realized, **the deficit will be greater**.
- If costs for the current Medicaid program and its current beneficiaries are higher than expected, or if more people become eligible and enroll, **the deficit will be greater.**
- **By adding the $66 million in state funds required for Catamount Health to the $212 million deficit in Medicaid, H. 816 requires Vermont to raise an additional $278 million for**

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government health care by 2010, just to break even on our promises.

Many legislators raised questions about the assumptions underlying the CG several months ago, expressing concern for the security of Medicaid. One legislator felt strongly enough to vote against the Global Commitment last fall: Rep. Michael Obuchowski (D-Rockingham). The Rutland Herald noted that Rep. Obuchowski, the Chair of the Ways and Means Committee, expressed a concern that "... the federal government's commitment ... for the program is insufficient to deal with any downturn in the state's economy..." **" 'I have some serious concerns, particularly if our economy is not so resilient,' Obuchowski said."** (12/14/05)

Unfortunately, Rep. Obuchowski and the Ways and Means Committee, and House Health Care are adding their plan into the GC's already capped budget. While The Blueprint's chronic care initiative is expected to reduce cost growth over the long term, the deficit is growing **now**. The legislature has dealt with the Medicaid problem in the past by cutting back on reimbursements to providers, but **business leaders in Vermont have made it clear that cost-shifting the deficit onto the cost of private insurance is no longer an option.** (Last year, for example, the $16 million cut in reimbursement to hospitals led to a rate increase to private payers of nearly 8% at some hospitals.)

None of the remaining solutions is pleasant, either. The legislature could **change the Medicaid program by changing eligibility and/or changing what benefits are covered.** The legislature could **raise taxes** to close the gap. Taking action is unavoidable, and delaying action only makes the impact worse. And certainly, **care should be taken to carefully and closely examine cost projections of any new programs or services added to the Global Commitment's budget at this time**. Regarding Catamount health, for example:

- The plan assumes there will be no more than 25,500 enrollees (cumulative) from 2007-10, but there is ***no mechanism in the bill to cap enrollment or expenditures*** if the budget is exceeded.
- Cost estimates for Catamount Health are based on ***8.5% annual inflationary growth. No state revenue source*** grows at even half that rate, should additional funds be needed.
- Cost estimates are based on demographics of the currently uninsured. If older or less healthy people become uninsured because employers drop their plans, ***if the "new pool" of uninsured who enroll are not as healthy***, the costs will be higher than assumed.
- The House bill reduces monthly premiums for Medicaid and VT Health Access Plan by 50%, in hopes of increasing enrollment in those programs, but assumes that no more than 4000 will be added by 2010 (and there is no mechanism to cap enrollment or expenditures if more apply). ***More and sicker people will add to both the Medicaid deficit and the cost-shift.***
- Concerns are being raised by many policy makers about relying heavily on the increased tobacco tax, which may decline ***if higher taxes help smokers quit, or if they buy elsewhere.***

Which begs for the following questions to be addressed to H. 861:

- **Can the cost of the Catamount Plan be scaled back to reduce how much "space" it takes up under the Global Commitment budget cap, so as to not increase the deficit or otherwise place the existing program at risk?**
- **Should there be a "second opinion" on the economic modeling used to project its costs before finalizing eligibility, benefits and subsidies in legislation?**
- **Should Catamount Health be assigned a global budget to ensure that it does not add to the Medicaid deficit?**

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- **What steps can the legislature take this year to immediately start to reduce the Medicaid deficit (without increasing the cost shift)?**
- **What steps can be taken now to stop the Medicaid cost-shift to private insurance?**

We already have a $212 million deficit to deal with. Shouldn't that be our priority? And shouldn't we be very careful before adding a new health care entitlement program under that same Global Commitment cap?