



Toward Evidence-Based Health Care Reform

Vol. 2, No. 9

An Open Letter to the Conference Committee: *Four small changes for budget integrity*

Since releasing our comprehensive proposal for health care reform in March 2005, we've been bringing forward evidence and analysis to get the best health care reform legislation possible for Vermont. We still hope meaningful legislation can be enacted this year, but believe there are still *serious, but fixable*, problems with H. 861 as passed by the Senate.

They are not simply issues of philosophical difference. They are fundamental issues of budget integrity and program sustainability, pure and simple. We recommend four simple changes that bring budget integrity to the plan:

- **Two of the changes are necessary to guarantee that Catamount Plan does not incur deficits that will add to the \$212 million deficit we already face in our Medicaid and VHAP programs.** One caps the cost of the Catamount benefit, the other caps the overall budget. The legislature needs to build budget integrity into the new plan. The alternative is a repeat of the hard-to-solve deficit crisis we already face year after year in Medicaid, now projected to total \$212 million in 2010.
- **One change would require the \$365-per-employee Employer Assessment, like the Employer-sponsored insurance (ESI) plan, to be studied prior to implementation.** This new fee and reporting requirement for all employers was added to the bill without any studies, impact statements or documentation of the number of employers affected, or the economic impact segmented by industry or business size. None of the legislature's assumption on this assessment have been examined, tested or validated. No assumptions have even been publicly released. These are exactly the same criticisms the legislature made of the governor's subsidy proposal for employer insurance. The legislature insisted that subsidy plan be studied first. If the subsidy must be studied first, certainly a brand new, multi-million dollar tax should be studied first, also.
- **One change would make the health benefit standard realistic and reasonable.** Two-thirds of the uninsured work for businesses with fewer than 25 employees. In businesses where 25 or fewer employees are insured, according to Blue Cross, **only 7% have a plan equal to the required Catamount Benefit Plan.** Unless this standard is changed, hardly any of the uninsured employees with access to employer plans will not be eligible for premium subsidies!

We understand this essay is long. **But now that Vermont is in the final moments of this important debate, we hope you'll agree it is worth 10 minutes to read and consider suggested improvements to what could possibly be one of the most important decisions our government will make for at least the next decade.**

Below we present our **four sensible changes** to H. 861 that will assure citizens Catamount Health won't inadvertently run up new deficits, impose extraordinary new costs on employers already offering health insurance to their employees, nor draw the currently insured into Catamount Health when it has not

been budgeted to cover them. For each issue we present what H. 861 says, identify the facts, define the problem and offer a sensible solution.

I. WHAT THE STATE PAYS FOR CATAMOUNT HEALTH BENEFIT PLAN MUST BE EQUAL TO WHAT THE LEGISLATURE BUDGETED FOR THE PLAN.
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What H. 861 says: Sec 15. §2024. Catamount health benefits. “The benefits shall be actuarially equivalent to the Vermont Free Plan with a preferred provider organization, \$200 deductible, and \$10 office co-payment offered by Blue Cross and Blue Shield of Vermont in 2006.” (p. 32). The legislature based the Catamount budget on their consultant’s projected cost of \$305 per person per month for this plan.

Facts:

- The “market rate” for this plan for a small business in 2006 is \$465 per person per month. Their consultant explains the price difference as a 9% reduction by subtracting administrative costs, 24% reduction because CH will pay hospitals and doctors less than BCBS pays them, and a 10% reduction because the uninsured population are healthier than the BCBS community rate dictates. He built in a small cushion and settled on \$305/person/month.
- The market rate of \$465 that the consultant used as the basis for cost is current: 2006. The consultant’s estimate of \$305 is for budget year 2008. So, the consultant’s reduced rate is not only lower based on specific assumptions about utilization and demographics, it is based on this year’s cost, when two more years will have gone by before Catamount is launched. If the \$465 is trended at 8.5% for two years, it will be \$547. Therefore, in 2008, the difference between the “market premium” and the “catamount premium” will be \$242 per person per month. This means that Catamount’s budget for 2008 is based on a plan projected to cost 56% less than market cost for the same plan.

Problem: What if the legislature’s budget underestimates the true cost of the benefits? Even if they have used the best available information today, what if:

- Sicker and older people enroll, not the young and healthy as they’ve assumed
- Utilization skyrockets above estimates when these folks have insurance for the first time
- Inflation is higher than projected
- The market rate in 2008 is actually a closer approximation of the true cost

If the legislature’s cost estimate is off by even a mere \$30 per person per month (that is, if CH costs \$335 instead of \$305/month), and only 10,000 people (1/2 of projections) enroll, CH would produce a \$3.6 million deficit that year. (\$30 X 12 months X 10,000)

Solution: **The only way to make sure that the cost for CH in 2008 matches what the legislature has budgeted is to cap the benefit cost to match the budget.** H. 861 requires the state go out to bid for CH. As the bill is written, the bid basically will say, “Quote us your cost for providing something as least as good as the BCBS Freedom 200/20.” What happens if the bids are all above \$305/person/month? The bid will have failed, and the responsibility then falls to the state to “self-insure” a plan that could not be insured at that price!

A very simple amendment turns the bid around, and protects the state budget and the Medicaid program from further deficits. With this amendment, the bid will say: “Give us the best possible plan you can for no more than \$305 per person per month. We’d like it to look as much as possible like the BCBS Freedom 200/20, but if it can’t, tell us what we’d have to adjust to stay in budget, and we’ll make that choice.”

Here is the current H. 861 language with the suggested amendment underlined:

“(b)(1) The benefits shall include primary care, preventive and chronic care, acute episodic care, and hospital services. The benefits shall be, insofar as is possible without exceeding a maximum cost of \$305 per month for an individual, actuarially equivalent to the Vermont Freedom Plan with a preferred provider organization, \$200.00 deductible, and \$10.00 office co-payment offered by Blue Cross Blue Shield of Vermont in 2006. “

II. THERE MUST BE A CAP ON ENROLLMENT THAT IS AUTOMATICALLY TRIGGERED IF THE OVERALL CATAMOUNT HEALTH PROGRAM COST EXCEEDS WHAT THE LEGISLATURE HAS BUDGETED.
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What H. 861 says: §2023(e)(1) (p 30) currently reads:

- (e)(1) If the monies available in the catamount fund established under section 2028 of this title are insufficient to support ongoing, new enrollment in catamount health, the agency shall recommend to the health access oversight committee a plan to cap or limit enrollment.
- (2) The agency’s determinations that monies available are insufficient shall be based on monthly enrollment figures and the official revenue estimates for the catamount fund under section 305a of Title 32.
- (3) A plan to cap or limit enrollment submitted to the health access oversight committee under this section shall be deemed approved unless the committee disapproves the plan within 21 days of submission by the agency.
(our emphasis added...)

Facts:

- This is not a cap on enrollment. This only requires the Secretary of Administration to *recommend* that the Health Access Oversight Committee (HAOC) *approve* a plan for a “cap.” A true cap is automatic, triggered by a specific, measurable event, is not optional and non-negotiable.
- The decision whether or not to impose an enrollment cap is left up to a committee (HAOC) whose charge is improving access to health care, not to a person (the Secretary of Administration) or committee (Joint Fiscal) whose charge is protecting the state from budget deficits. Moreover, the committee’s composition is neither balanced nor even representative of the Assembly: (8 Democrats and 2 Republicans.)
- The overall budget for H. 861 is based on numerous assumptions that may or not hold true two years from now, such as:
 - No more than 2600 individuals will transfer from private insurance plans to CH
 - The \$305/person/month premium is adequate funding for this benefit design
 - The employer assessment can be implemented without causing serious economic dislocation.
 - ESI is implemented, subsidies for those folks are within budget projections, and VHAP enrollment declines as a result.

- Cigarette tax revenues won't decline at a steeper rate than expected
- Enough CH enrollees will have incomes high enough to allow projected collection of millions of dollars in premiums.
- Low-income CH enrollees will not need higher subsidies than predicted.

Problem: This bill does not provide a cap on enrollment in the event the overall budget is exceeded for any reason. If any of the assumptions listed above are off, the budget is busted. A combination of them in the wrong direction could be fatal.

The HAOC could outright disapprove the recommended cap, thereby not allowing a suspension of enrollment. HAOC could disapprove the plan while initiating a study, or decide to wait for additional revenue estimates, etc. Meanwhile, enrollment would continue unabated, running up the deficit with every new person who enrolls. At a "premium" of \$305/person/month, **the enrollment of even 500 more people for one year creates a \$1.83 million deficit** (\$305 X 500 X 12).

Solution: The only way to **make sure** that unexpected enrollment, migration from private insurance, missed projections or other anticipated problems don't create deficits is to **set a "hard" cap on enrollment, with a specific trigger**. The following language from the health care reform bill passed recently in West Virginia is an example of a hard cap, to be triggered if federal matching funds change from what that legislature assumed in their budgeting for the program:

In the event that federal funds are no longer authorized for participation by individuals eligible at income levels above two hundred percent, the board shall take immediate steps to terminate the expansion provided for in this section and notify all enrollees of such termination. (WV H.B. 4021)

An amendment to Vermont's H. 861 imposing a hard cap would read:

(e)(1) If the monies available in the catamount fund established under section 2028 of this title are insufficient to support ongoing, new enrollment in catamount health, the agency shall ~~recommend to the health access oversight committee a plan to cap or limit enrollment. take immediate steps to suspend further enrollment in catamount health, and shall notify all pending enrollees of such suspension.~~

(2) The agency's determinations that monies available are insufficient shall be based on monthly enrollment figures and the official revenue estimates for the catamount fund under section 305a of Title 32.

(3) ~~Immediately upon suspension of enrollment, the agency shall A plan to cap or limit enrollment submitted to the health access oversight committee and the joint fiscal committee findings upon which the decision to suspend enrollment was based. under this section shall be deemed approved unless the committee disapproves the plan within 21 days of submission by the agency.~~

At that point, discussions may ensue between the administration and legislature to identify the cause(s) for the insufficiency of monies to support ongoing enrollment in CH, and to propose statutory changes that would remedy the insufficiency and allow enrollment to recommence.

III. The Assessment on employers must be subjected to the same rigorous examination as the Employer-Sponsored Insurance (ESI) initiative, prior to implementation.

What H. 861 says: **Sec. 25a Employers' Health Care Premium Contribution.** The purpose stated in the bill itself is to share "costs with employers who do not offer their employees health care coverage."

(§2001, p.48) The “premium” of \$91.25 per quarter per full time equivalent uninsured employee (FTEUE) is assessed for any “uncovered employee,” defined in the bill as:

- “(A) an employee of an employer who does not offer to pay any part of the cost of health care coverage for its employees; or
- (B) an employee who is not eligible for health care coverage offered by an employer to any other employees.
- (C) **an employee who is offered and is eligible for coverage by the employer but elects not to accept the coverage and has no other health care coverage under either a private or public plan.”**

Part (c) was added by the Senate during third reading. There was no committee testimony taken on this extremely significant, last-minute change to the assessment.

Facts:

- Objections raised by legislators to the Governor’s ESI proposal were that the impact on employers was unknown, untested and unfair; that projections of costs of subsidies and cost-offsets from employer coverage were not backed up with rigorous and credible study; and that the program would add layers of complexity and confusion that had not been adequately assessed.
- The same objections apply to the Senate’s “Employer Health Care Premium Contribution,” which was put in H. 861 without any rigorous or credible study as to its impact on employers, how it would be administered, and how much revenue it would raise. In fact, **no document was publicly released describing the assumptions on which this assessment has been based.**
- The addition of category “C,” employees, who are offered coverage but refuse to accept it through no fault of the employer, totally violates the purpose of this assessment, is unfair, and will require every employer in the state to file quarterly reports.
- To file an adequate quarterly report, an insuring employer must determine, quarterly, which employees who did not enroll in the plan have coverage elsewhere. We must assume that to avoid paying an assessment for those employees, the employer would need to document any other coverage the employee has.
- Compliance with reporting applies to all Vermont wage-paying employers, not only to those who do not offer insurance. This bill places the burden of proof on every employer to show they are NOT subject to the assessment.

Problem: We have tried to obtain estimates of the cost of this assessment for several employers who do offer insurance but not all employees accept it. They told us based on information they currently have, that they cannot determine whether employees have coverage elsewhere. That would have to be collected only for the purposes of avoiding this assessment. Also, employees cannot be required to provide documentation to assist the employer. One employer estimated, based on experience of examining how many employees had spouse coverage, that a successful hunt for documentation took more than one hour per employee.

An employer in the hospitality industry told us that many of their seasonal workers may qualify for insurance but decline it, because they are nationals of other countries. She asked us: if they decline our insurance because they are only here for four months and then return to their home country where there is a national insurance plan, does that mean I pay the assessment or not?

Another employer told us they could not estimate their liability without extracting from the payroll reports the hours worked by each employee who declined coverage without coverage elsewhere. She asked: what if they are salaried instead of hourly? How is paid versus unpaid leave treated? Are we assessed for someone who leaves in the middle of the quarter or not?

Many questions like this are unanswerable because there has been no study of the practical aspects, nor economic impact, of this proposal, and the ramification for employers in terms of administrative burden and cost are wholly unknown and unpredictable.

There is also a very real danger that a significant number of employers – large and small - who do provide good coverage will be nonetheless be assessed a substantial fee for part-time and non-participating employees under this new scheme. They will be compelled to compare the cost of the assessment (\$365/employee/year) to the cost of providing substantially similar coverage for their remaining insured employees ($\$465 \times 12 = \$5,580$ /employee/year). It doesn't take a Nobel Prize in economics to see the incentive to simply drop their own plans and pay the assessment for all. That might make great financial sense for the employer (\$365 versus \$5,580 per employee per year) but it would be terrible for the state, which will be collecting \$365/employee/year for people who come to Catamount but costs the state \$305/person/month!

The legislature has provided no documentation whatsoever on the number of employers affected by this provision and the economic impact on employers by size, by industry or by any other segmentation. The potential for migration to CH because of this assessment is unknown. The cost of administering this fee system, which requires reporting by every employer in Vermont, has not been quantified. The cost to employers for documenting and remitting to the state on a quarterly basis has not been quantified. The impact of this assessment on multi-state employers, small businesses and the hospitality industry, so vital to our economy, is totally unknown. No credible impact study was conducted by the legislature. **This subjects this proposal to the same criticism they made of the governor's ESI: study and verify prior to implementation.**

Solution: Sec 11g of the bill states that no more than \$250,000 may be expended on the ESI program until "additional information and analysis is provided to determine the specific parameters involved in an employer-sponsored premium assistance program," costs, and savings to VHAP. Additional funds can be expended on ESI only upon approval by a majority of the combined membership of the joint fiscal and health access oversight committees.

The proposed assessment on employers also needs rigorous study, even more so than ESI because the reporting requirement will affect every single employer in the state, and because this is a tax or assessment with unknown consequences across the economy. The potential impact is so much greater than for ESI that this proposal must be subjected to rigorous study and analysis prior to the entire legislature "green lighting" implementation of the assessment.

We propose that along with the study of ESI, the Agency of Administration report to the 2007 General Assembly on the economic impact, cost of administration, revenue estimates and other impacts of this assessment, that that the assessment be implemented only upon approval by a majority of both houses, and the signature of the governor.

IV. IF WE WANT TO PROVIDE SUBSIDIES FOR THE UNINSURED EMPLOYEES TO “BUY INTO” THEIR EMPLOYER PLANS, THE STANDARD FOR A QUALIFYING EMPLOYER PLAN MUST BE REALISTIC AND REASONABLE.

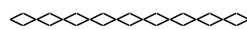
What H. 861 says: Sec. 11. Premium assistance program; employer sponsored insurance (p. 22). Employee must be offered an “approved employer-sponsored insurance plan” to qualify for premium assistance, or to be required to transfer from VHAP to the employer plan. (Sec 11a and 11b) The criteria for an “approved” plan will be developed by BISHCA and AHS, and must be, at a minimum, “substantially similar, as determined by the agency, to the benefits covered under Catamount Health.” (Sec 11d). According to estimates developed by consultant Ken Thorpe, 7,457 (25%) of the 30,247 to be helped by this bill are employed-uninsured who would be helped specifically by the ESI provision.

Facts:

- According to preliminary results from the April 2006 BISHCA survey of the uninsured, **3 out of 5 of the employed-uninsured work for businesses with < 25 employees.**
- According to Blue Cross and Blue Shield, **only 7% of businesses where 25 or fewer employees are insured have a plan equal to the required Catamount Benefit Plan.**

The Problem: For ESI to actually work for the 7,457 folks projected to be helped by the bill, the employers of employed-uninsured must have plans that can be “approved.” **The facts show that only 7% of employers where most of the employed-uninsured work have such plans.**

The Solution: Allow BISHCA and AHS more flexibility in defining the qualifications for an “approved plan.” For example, if the employer plan has a higher deductible than the CH plan, but the state’s subsidy for cost sharing allowed in the ESI proposal would result in benefits “substantially similar” the CH plan, that employer plan should be approved. The current bill **requires the plan itself to be “substantially similar.”** However, if the plan plus the ESI subsidies provide coverage in combination that is “substantially similar,” the employer plan should be approved. In other words, focus on the employee’s total coverage including subsidies, not on the employer’s plan only.



From the beginning of this historic debate on health care reform, we’ve looked for the best way to cover the uninsured, bring down the rate of cost increases, eliminate the cost shifting, make our government health programs sustainable, and not wreck the economy and jobs in the process.

While there are still numerous smaller problems in the bill, we believe that people acting in good faith can work them out together during implementation.

However, these four sensible changes are needed for reasons of basic fiscal responsibility and can bring we hope they can bring all of us to “yes” on this historic and important legislation.