



Toward Evidence-Based Health Care Reform

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Paths Cross at 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: www.brsvt.com

To review past issues of Toward Evidence-Based Health Care Reform, www.vtreform.com.

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When Acts 191 and 215 establishing the Catamount Health Plan were passed in the 2006 session, several assumptions adopted during the debates and compromises were embedded in these laws. Those assumptions are integral to the financial sustainability of Catamount Health; the state literally cannot afford to ignore them. Unfortunately, bills, budgets and other initiatives floated this year by many of the same legislative leaders appear to subvert, undermine and even contradict the very assumptions they used to build Catamount Health. Here are the three key assumptions at risk:

1. Catamount would cover only the currently uninsured, who are a relatively young and healthy population. According to the legislature's consultant, Kenneth Thorpe, the uninsured are so much younger and healthier than the insured population, he predicted the Catamount premium to cover them would be 10% lower than commercial premiums. The legislature and governor relied upon this projection of a very young and healthy pool, in establishing the five-year budget for Catamount Health Plan. Simply put, if the risk pool for Catamount Health is not as healthy as described last year, the costs will be higher than predicted. (See http://www.leg.state.vt.us/CommissionOnHealthCareReform/thorpe_presentation_on_ch_rev_041206_files/frame.htm , slides 4, 5)
2. Catamount Health Plan should not replace existing insurance coverage, including employer-sponsored and individual private insurance. The legislation was based on agreement that it is not good

public policy for a government plan to "crowd out" private coverage. State funds should be reserved for the uninsured. Also, it costs the government more money to cover people who already are covered (because the employer contribution to premium is lost in government plans), and it destabilizes the private market when selected groups move back and forth between pools. To prevent crowd-out, the legislature's consultant strongly defended the need for a waiting period of at least 12 months after the end of coverage before being eligible for Catamount so that people wouldn't drop private coverage to enroll in CH. He cited his own and other research on the importance of preventing crowd-out to maintain budget integrity for government programs. Thus, to be eligible for Catamount, one must be uninsured for at least 12 months, except in limited, specific circumstances that are out of the control of the individual (loss of employment, death of spouse, etc) (See: http://www.leg.state.vt.us/CommissionOnHealthCareReform/thorpe_presentation_on_ch_rev_041206_files/frame.htm , slide 1)

3. Better management of chronic disease should reduce health care spending over time. While this concept is widely supported, the legislature was particularly enthusiastic about the potential cost savings from The Blueprint for Health Chronic Care Initiative, a statewide, integrated effort to provide evidence-based primary care, to give patients better tools and support for self-management of their diseases, and to coordinate the work of all state agencies toward shared goals on chronic care. In fact, the legislature believed so strongly in the potential for savings that they declared the savings to be actual, rather than potential. To balance the budget for Catamount Health, the legislature is counting on \$26 million in reduced spending on the Medicaid program because of the Blueprint by 2010. (See: Catamount Health balance sheet at <http://www.leg.state.vt.us/jfo/Healthcare/H.861%20Balance%20Sheet.pdf>)

Other than disagreements about whether \$26 million in chronic care potential savings were solid enough to be budgeted, there was broad acceptance of these assumptions. But it look like that was then, and this is now.

In the hearings of the Legislative Committee on Administrative Rules (LCAR) last Fall, legislators claimed that it was always their intention to allow people who quit their jobs or retire early to immediately get into Catamount Health (that is, be exempt from the 12-month waiting period). With all due respect, retirees will be older and likely sicker than the general population --- not at all what was predicted for Catamount, which was the young and healthy uninsured population. By allowing currently insured individuals to retire and move into Catamount, the legislature is significantly changing the composition of the pool of individuals Catamount will cover, in all likelihood making it much more costly than last year's estimates. Last year, it was only the young and healthy uninsured; now the pool will include people who were already insured but retire (and might have been working only to keep their health insurance because of health problems...)

Allowing people who quit or retire from their jobs to immediately sign up for Catamount also increases the opportunity for Catamount to crowd out private coverage. Insuring via Catamount will cost the state more than subsidizing employer coverage because there is no an employer sharing of the premium in Catamount Health. However, as a result of the strong pressure from LCAR, BISHCA was forced to change their proposed regulations to allow early retirees and those who voluntarily quit their jobs to be immediately eligible for Catamount. BISHCA notified the carriers of this change so underwriters could make adjustments to the Catamount Health premiums.

Several bills have been introduced this year by leaders in last session's Catamount Health debate that would directly contradict the assumptions about the healthy risk pool, prevention of crowd out, and the importance of the Blueprint for Health model for chronic care. For example:

- S.95 (introduced by Sen. Ann Cummings) would remove the waiting period before currently insured small businesses can be eligible for Catamount Health, and S.49 (introduced by Sens. Mullin and Kittel) would do the same for farmers and agricultural workers. Some Senators are discussing adding non-profits and the self-employed. This means that any small business, as defined in the bill, and any farmer (and possibly non-profits and self-employed) can drop their current insurance and they and their employees can enroll in Catamount without the 12-month waiting period currently in the law. This totally contradicts and subverts the protections against crowd out carefully built into the plan. This also potentially could degrade the Catamount Health risk pool, because the principle reason businesses would shift to Catamount Health is for richer benefits to cover their health problems. Remember, if they don't currently have insurance, they are already eligible for CH. These proposals make currently insured people also eligible for CH.
- H.82 (Grad, Milkey, Westman, Brooks and a dozen others) and S.39 (Miller, Ayer and five others) would mandate that insurance companies cover medically necessary services provided by naturopathic physicians. It's confusing how this fits with the legislature's vision of standards-based, measured and monitored evidence-based management of chronic illness as embodied in the Blueprint for Health, when very little of what naturopathic physicians do is measurable using recognized standards, aligned with the Blueprint's care standards for chronic illness, or evidence-based.
- S.180 (Sens. Flanagan and White) would allow farmers and small businesses into Catamount Health without a waiting per S.49 and S.95 (see above), and would also let into CH anyone whose family has spent 10% or more of the family's income on health care expenses (defined as premiums, co-payments, cost sharing and other out-of-pocket payments; these folks are defined as "underinsured" by the bill). Clearly, any family spending that much has at least one extremely ill member. And while this family may deserve public assistance, this category of participant was not at all considered as part of the demographic pool for Catamount Health, and would significantly impact claims and therefore premiums and costs for the plan.
- The battle-royale in the past month between legislative leaders and governor over proposed uses of the employer assessment funds also might subvert last year's assumptions. According to Act 215 (the Budget act that contained the assessment),

All monies received by or generated to the fund shall be used only as allowed by appropriation of the general assembly for the administration and delivery of the Catamount Health assistance program under this subchapter, employer-sponsored insurance premium assistance under section 1974 of this title, immunizations under section 1130 of Title 18, the nongroup health insurance market assistance under section 4062d of Title 8, and for transfers to the state health care resources fund established in section 1901d of this title as approved by the general assembly.

This means the assessment fund may be used for administration and delivery of Catamount Health assistance programs, employer-sponsored insurance premiums, free immunizations, subsidizing the non-group market, and for transfers to the state Medicaid fund. Our question is this: because funding for Catamount Health is significantly dependent upon savings generated from the Blueprint for Health, are not expenditures on the Blueprint for Health part of the administration and delivery of Catamount Health? How can the savings be generated if the Blueprint isn't adequately funded? Because the legislature is counting on these savings, shouldn't they be sure that they adequately fund the Blueprint investments?

And then there's S. 62 (Sens. Ayre, Bartlett, Campbell and others) which would allow divorced spouses of employees to remain on the ex-spouse's insurance coverage indefinitely. Whoa! Those people are already specifically eligible to be immediately enrolled in Catamount Health without a waiting period. Why are they even proposing this bill? Do they want people to move into Catamount or stay in employer plans? It's hard to tell by the legislation being proposed what their priority is any more.