



## Toward Evidence-Based Health Care Reform

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***We can't afford any more savings . . .***

*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.*

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Health care "reforms" this year are packaged in terms of "savings." And if you don't have the time or know-how to analyze and dispute the claims of "savings," it's hard to vote against them. To further confuse things, the changes are now called "fees," "eligibility expansions," "investments," and "system costs" instead of "mandates" and "taxes." We are being told they will generate "savings" far in excess of the cost of any mandate, tax, or expansion.

So far, the following bills have passed at least one chamber in the General Assembly, with a promise of "savings" to the people who will pay for them. ***But there is only one group paying for all this: people with private health insurance. And the savings? You do the math . . .***

- ◆ **VITL tax on private insurance (cost: \$27 million over 10 years)** Without any study of whether taxing private insurance was the fairest or best way to fund electronic medical records for Vermont doctors, and without a firm legal opinion that it can be successfully defended in federal court ("the ERISA problem"), the House passed a tax on private health insurance to create a fund to pay 75% of the cost of computerized medical records for doctors.

Spreadsheets presented hundreds of millions in "savings" that justified taxing private insurance. **The problem is that the report the committee's "savings" figures came ("Bending the Curve") from says, on p. 13: "Net savings would accrue by year 10 to all except private payers, which would realize cumulative savings in following years."** Please read that sentence again. In other words, the very study used to justify this insurance tax points out that *private insurance won't see savings for at least ten years, which is the lifetime of this tax on private insurance.*

Did anyone actually read the study they are using to justify taxing private insurance based on savings? What other claims were made about insurance savings that were flat-out wrong? For example, the other "study" used by VITL and legislators to justify a tax on private insurance supposedly says that physicians realize only 11% of savings. This "study" is noted in VITL's State HIT Plan, p. 73. The "11%" figure is footnoted, and that footnote leads you to a New York Times article that quotes a doctor saying his group did a study. **What study and what else does that study say?** Is this any way to justify a \$27 million tax on private health insurance?

(And the New York Times article begins, ironically enough: "Saving money can be expensive.")

- ◆ **Mandated coverage of adult non-dependent children and divorced spouses (cost: \$16-\$32 million)** Advocates say they can't get the 18-24 year olds to sign up for Catamount and that mandating their coverage under the parent's employer-sponsored plan will get us closer to the legislature's goal of "96% insured." Catamount enrollment is five months old – maybe they're

giving up on Catamount too soon? (because the mandate is so much easier?)

The House committee said this mandate will cost “only 1-2% of premiums.” In real numbers, that means a \$16-\$32 million increase in premiums in one year, which will compound at health care inflation year after year. We’ve been told there isn’t a cost because we’ll “save” --- by not having those kids walk into the hospital uninsured. Well, premiums WILL go up for sure, but if those newly insured kids go to the hospital, how exactly do we get our “savings” back? The “uninsured” cost shift is still built into the hospitals’ 2008 rates --- there’s no law that reduces hospital rates just because people are now enrolled in Catamount or other insurance. The cost shift continues, AND we pay higher premiums. What savings?

- ◆ **Mammogram copay capped at \$25 (cost impact yet unknown)** Because private insurance will save so much for early detection and treatment of breast cancer, this bill caps the copayment for mammograms at \$25. Insurance will have to pay the balance, which varies significantly around the state, from a low of \$83 at Copley and Rutland, to a high of \$339 at Fletcher Allen.

While copayments may have been an obstacle for the women who testified in support of this bill, and we need to prevent breast cancer, it’s not at all apparent that the increased premium cost for this mandate will be made up for in savings from earlier detection and treatment, as alleged. Simply lowering the copay doesn’t make women get mammograms, and doesn’t mean a cancer will be detected early enough or is treatable. What evidence was provided, other than anecdotal testimony of specific cases, that private insurance will save more than this mandate will cost? Premiums WILL go up, but we can’t be sure of any savings. Expanded eligibility for Ladies First, a combined *outreach, education and screening campaign*, makes so much more sense, and might actually result in savings, because more women will actually get mammograms.

And some members of the House and Senate members want to add colonoscopy to the \$25 cap mandate, with hospital charges varying even more: \$858 at Rutland to \$3402 at Gifford. Maybe if the hospital charge were also mandatorily capped, the private insurance *might* realize savings? Why should only the privately insured bear the cost of this societal good?

- ◆ **Provider Tax Change (cost: \$16 million)** VT Hospitals are currently taxed to draw down federal matching dollars, and up to now have been “made whole” later for the tax. The budget that passed the House includes the Governor’s proposal to short-change the payback by \$16 million. The “savings” from not making the hospitals whole goes somewhere else in state government, while the shortfall will be made up in higher charges next year to private insurance. Yes, increased cost shift, increased premiums, no savings.
- ◆ **Medical Home Pilot (cost impact yet unknown)** House Health wants to mandate that private insurance plans conduct pilot projects for the Blueprint for Health’s vision of “medical homes” for patients. The pilot projects (yes, pilots –untested redesign of the delivery system) would be conducted for the Blueprint, a state government initiative, and the mandated participation, including a mandate of partial financing, is the legislature’s idea. At this point, the carriers have been shown no evidence whatsoever of a positive return on investment. Their costs (personnel, payments to providers, other costs of ramping up, operating and evaluating these pilots for the Blueprint) will be charged to us in higher premiums, and maybe someday, if this model “works” and is universally implemented (rather than one of the other pilots the legislature is directing) there might be savings. Increased insurance costs, increased premiums, any savings?
- ◆ **“Normal” Medicaid cost shift (cost \$90+ million)** As far as anyone can tell, the House’s budget for Medicaid does not reduce the cost shift, and may not even keep up with inflation; meaning: more cost shift and increased premiums.

Let's not forget past legislation that was supposed to "save" money for us:

- ◆ The 2006 Employer Assessment that funds Catamount Health, to reduce the cost shift from the uninsured. (Except there's no mandatory reduction in the hospitals' "uninsured cost shift" when people enroll in CH.)
- ◆ Mandated coverage of nutrition education and counseling more than ten years ago, which was supposed to save us millions by preventing the potential obesity and diabetes epidemic, which is now responsible for a lot of our health care costs.

This isn't to say that any of these initiatives is a bad idea. However, if the only possible funding source is cost shifting and taxes on private insurance, maybe we should evaluate whether we can truly afford to do all of these good things. If the legislature now has to make budget cuts because of declining revenues, and can't convince voters these projects are worthy of new income taxes, why does the legislature think that the privately insured can carry these new costs?

**Please! We can't afford any more savings.**