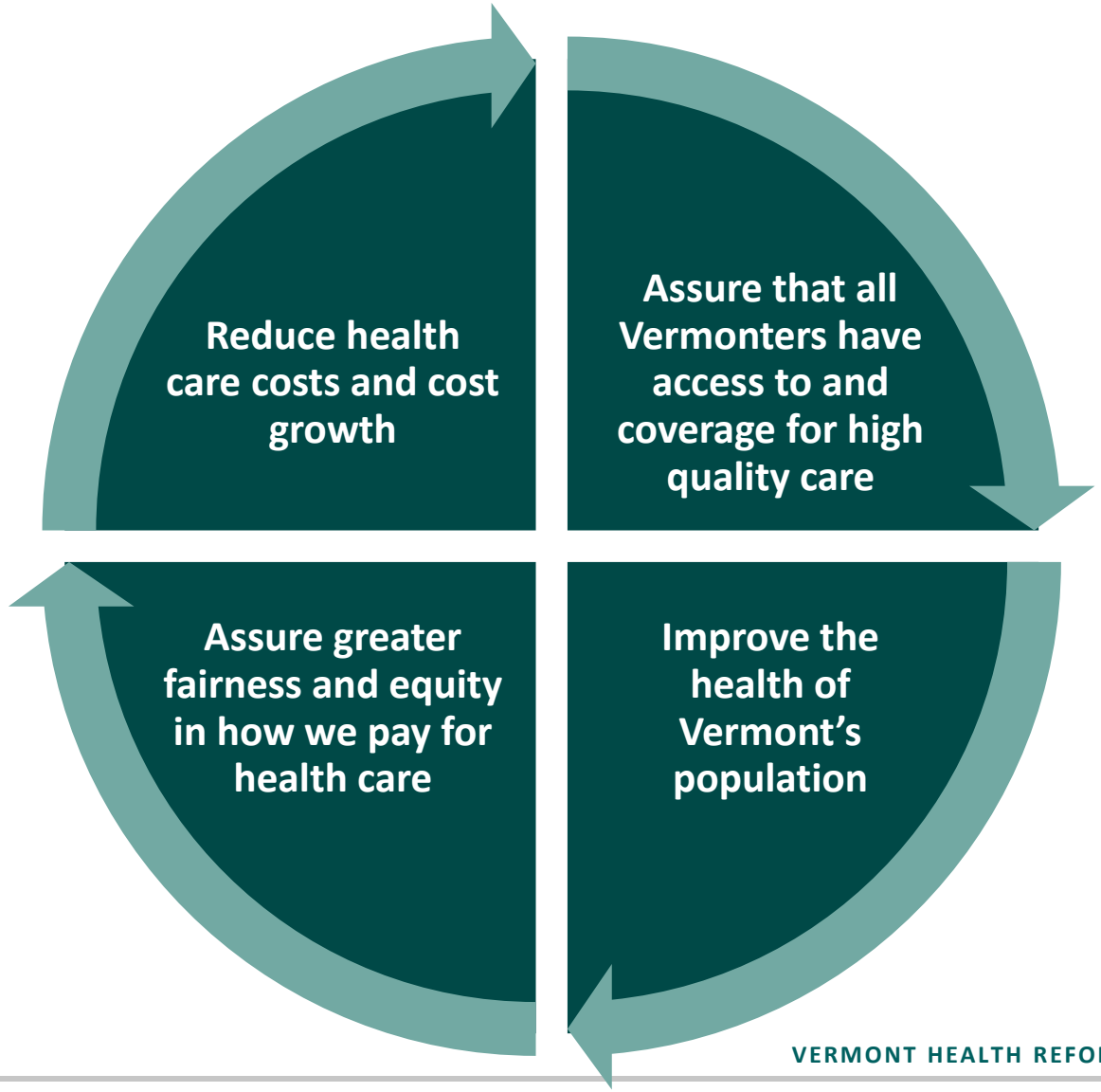
Financing Plans: 2014 - 2017

Robin J. Lunge, Director of Health Care Reform
Mark Larson, Commissioner, DVHA

GreenMountainCare
A HEALTHIER STATE OF LIVING

Health Reform Goals



What are the financing plans?

- In 2011, the legislature enacted a plan for moving toward the goal of a single payer system in Vermont. Act 48:
  - put in place the outline for universal coverage,
  - created the Green Mountain Care Board to address health care costs, and
  - created the Exchange as a stepping-stone toward Green Mountain Care, a system of universal coverage for Vermonters.

- Under Act 48, the administration is required to deliver two plans to the legislature
  - "2014 plan": 3 proposals to assure availability and affordability of coverage during Vermont's transition to Green Mountain Care
  - "2017 plan": describes costs, benefits, and potential funding sources for Green Mountain Care compared to today's costs

2014 FINANCING PLAN

2014 Financing Plan

- Funding of Vermont's Exchange (Vermont Health Connect), including resources to support Vermonters in understanding the Exchange and their choices for coverage;

- Funding to assure that coverage provided by qualified health plans purchased through Vermont Health Connect will be affordable for low and middle-income Vermonters, including those who have been covered previously by VHAP and Catamount Health;

- Funding to address the "cost shift" between Medicaid and private payers, relieving some pressure on private health insurance cost growth.

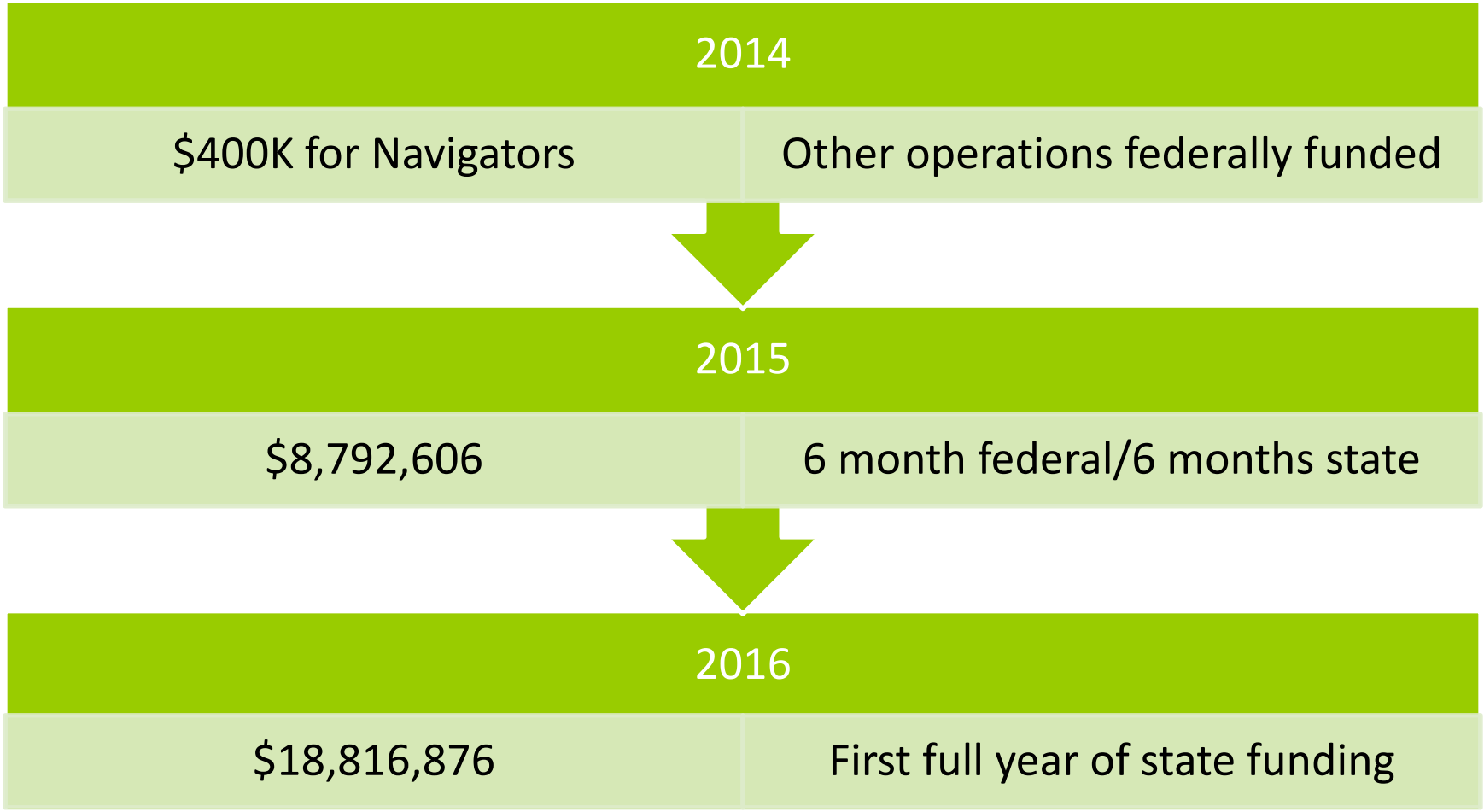
2014 financing plan: key policy decisions

- The Affordable Care Act does not provide enough funding to assure availability of health insurance to low and moderate-income Vermonters – more state funds are necessary to augment
- State government (Medicaid) should recognize growth in health care costs in the same way that other payers do

2014 Financing Plan

- Vermont Health Connect Financing
- Affordability
- Premium Relief Privately Insured Vermonters: Addressing the "Cost shift"
- Revenue Proposal

Vermont Health Connect Financing



VHC: Projected Cost Range

	Total Cost		PMPM Cost	
	Low	High	Low	High
Key Variables				
Members			70,800	118,000
Member Months			838,759	1,397,924
Operating Expenses				
Customer Service	3,106,633	4,711,334	3.70	3.37
Exchange Solution	5,645,404	7,565,013	6.73	5.41
Subtotal - Systems Development and Support	**8,752,038**	**12,276,347**	**10.43**	**8.78**
Outreach & Education	1,817,775	1,835,480	2.17	1.31
Consulting & Professional	1,287,934	1,390,088	1.54	0.99
Salary & Benefits	3,109,703	3,109,703	3.71	2.22
General & Administrative	1,288,456	1,288,456	1.54	0.92
Facility & Related	117,350	117,350	0.14	0.08
Appeals Program	584,858	930,224	0.70	0.67
Subtotal - Program Operations	**8,206,076**	**8,671,301**	**9.78**	**6.20**
Total Operating	**16,958,113**	**20,947,648**	**20.22**	**14.98**

2014 Financing Plan

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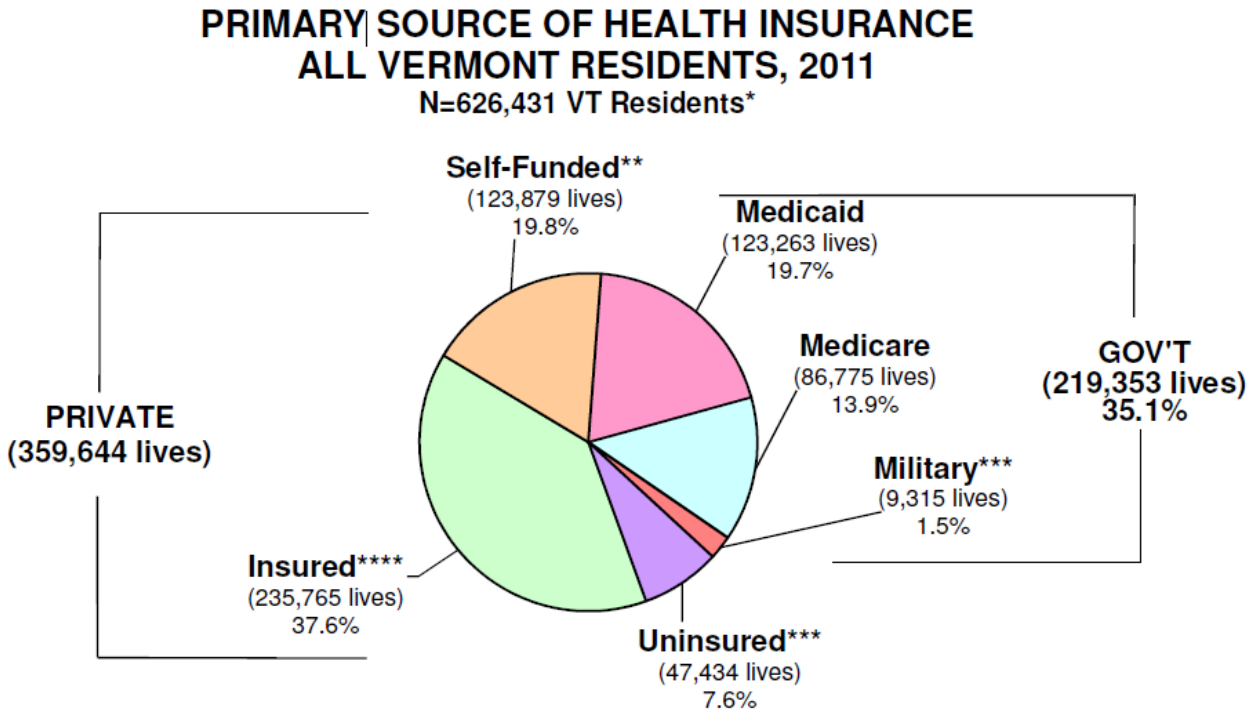
Current Health Care Coverage



* 2011 U.S. Census Bureau state-level annual population estimate and provided by VT Dept. of Health
** VT Department of Financial Regulation (DFR) does not regulate or collect data on Self-Funded. This is an estimate of the total Vermont lives covered by Self-Funded plans which includes Federal Employees Health Benefit Plan
***2009 Vermont Household Insurance Survey number trended forward and weighted based on the U.S Census Bureau uninsured estimates. The Household insurance survery is currently underway again and these numbers will be upated accordingly
****This number includes 51,358 Vermonters covered by health plans licensed in other states.

Migration Predictions-2014 Enrollment

Individual	58,515
Small Group	36,487
Medicaid (All, not just Primary)	159,191
Total	254,193*

*Assuming 4% Uninsured

2014 Migration: Privately Insured

		2012 Members	2014 Uninsured 4%
Privately Insured			
	Individual Except Catamount	4,014	58,515
	Catamount	14,069	0
	Federal	17,173	17,173
	Small Group	40,829	24,205
	VEHI/VADA	44,062	44,062
	All Other Association (assumed SG)	20,716	12,281
	Large Group	63,859	62,910
	Subtotal Underwritten	204,721	219,147
	Self-Insured	143,105	140,979
	Total Private	**347,826**	**360,125**

VHAP & Catamount Transition

- VHAP and Catamount programs will end, with current beneficiaries moving into other programs

	2012 Population	2014 Migration	
		Medicaid	Exchange QHP
VHAP	38,602	28,587	10,015
Catamount	11,427	2,294	9,133

Federal Premium Tax Credits

Department of Vermont Health Access
ACA PREMIUM LEVELS IN 2014

2011 FPL range	Income (1 person)	Premium for 1-person household	
	Monthly income	% of income	Monthly amount
0-100%	$0-$931	0.0%	$0
100 - 133%	$932-$1238	2.0%	$19-$25
133 - 150%	$1239-$1397	3-4%	$37-$56
150 -200%	$1398-$1862	4-6.3%	$56-$117
200 - 250%	$1863-$2328	6.3-8.1%	$117-$189
250 - 300%	$2329-$2793	8.1-9.5%	$189-$265
300 - 350%	$2794-$3259	9.5%	$265-$310
350 - 400%	$3260-$3724	9.5%	$310-$354

2011 FPL range	Income (4 people)	Premium for 4-person household	
	Monthly income	% of income	Monthly amount
0-100%	$0-$1921	0.0%	$0
100 - 133%	$1922-$2555	2.0%	$38-$51
133 - 150%	$2556-$2882	3-4%	$77-$115
150 -200%	$2883-$3842	4-6.3%	$115-$242
200 - 250%	$3843-$4803	6.3-8.1%	$242-$389
250 - 300%	$4804-$5763	8.1-9.5%	$389-$547
300 - 350%	$5764-$6724	9.5%	$548-$639
350 - 400%	$6725-$7684	9.5%	$639-$730

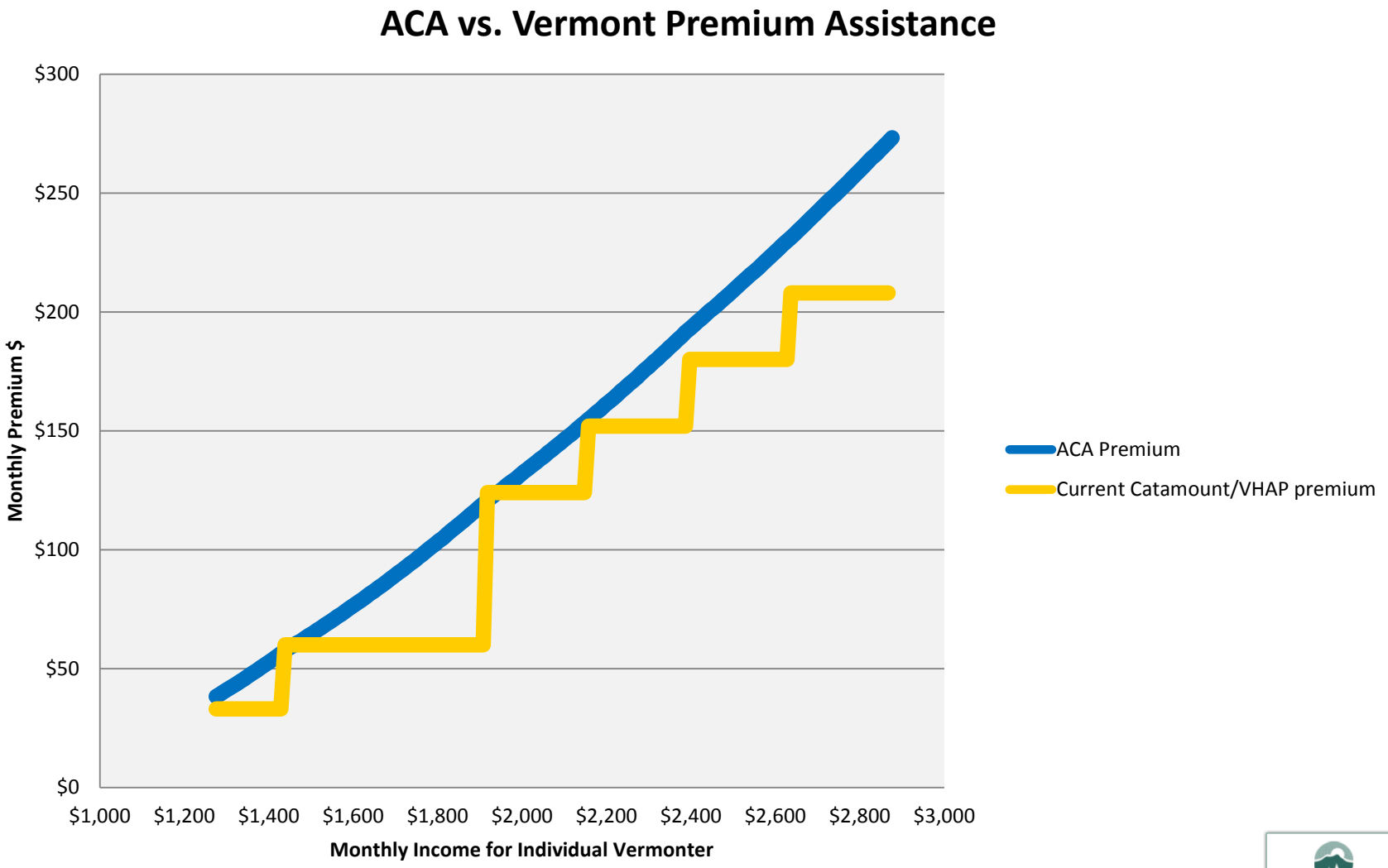
Federal Cost-Sharing Assistance

	Medical Deductible	
FPL	ACA	Catamount
133-150%	$100	$500
150-200%	$500	$500
200-250%	$1,900	$500
250-300%	$1,900	$500

	Medical OPM	
FPL	ACA	Catamount
133-150%	$600	$1,050
150-200%	$1,000	$1,050
200-250%	$3,200	$1,050
250-300%	$5,000	$1,050

Primary care visits and other preventive medical services are covered without cost-sharing

The ACA is less affordable for Vermonters



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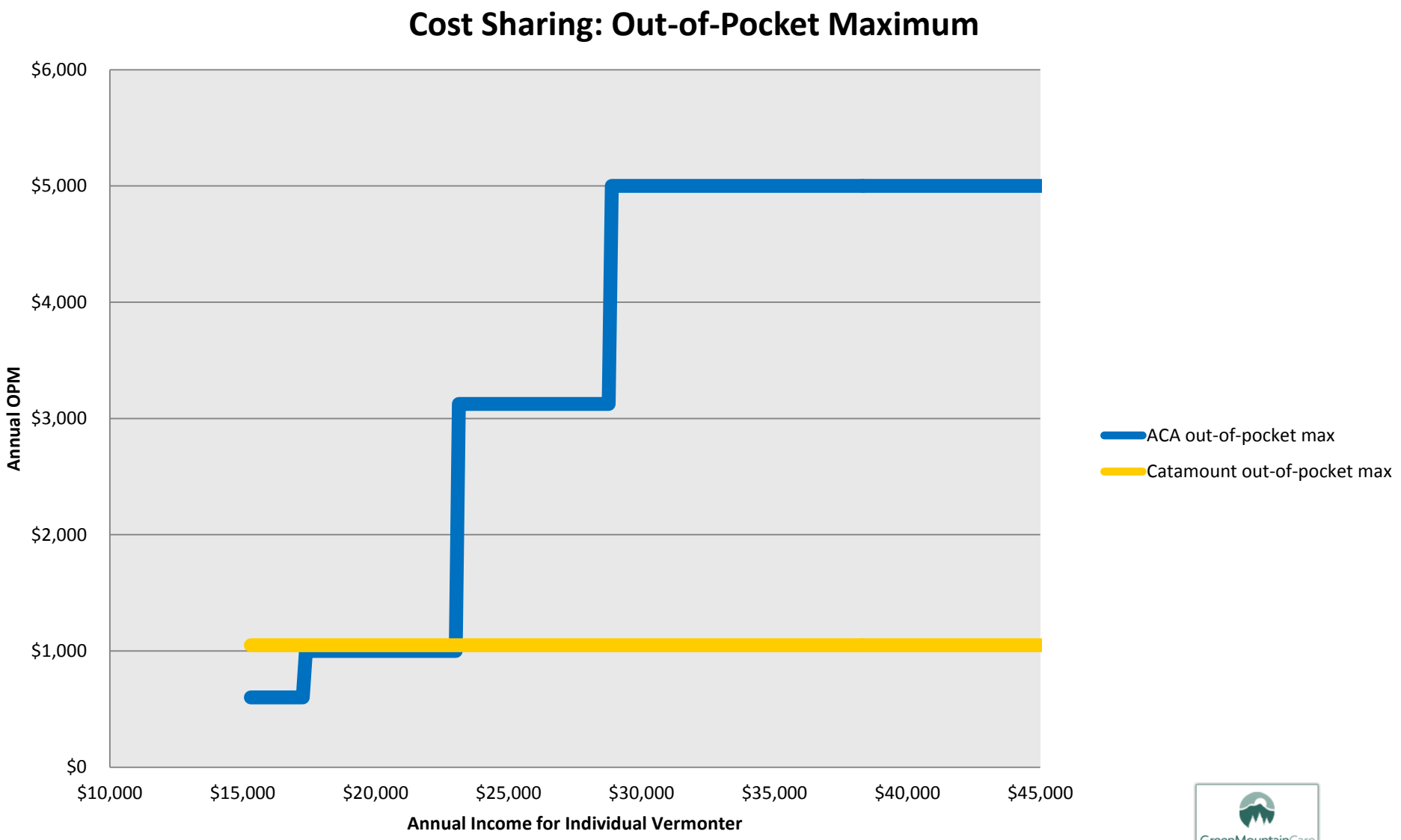
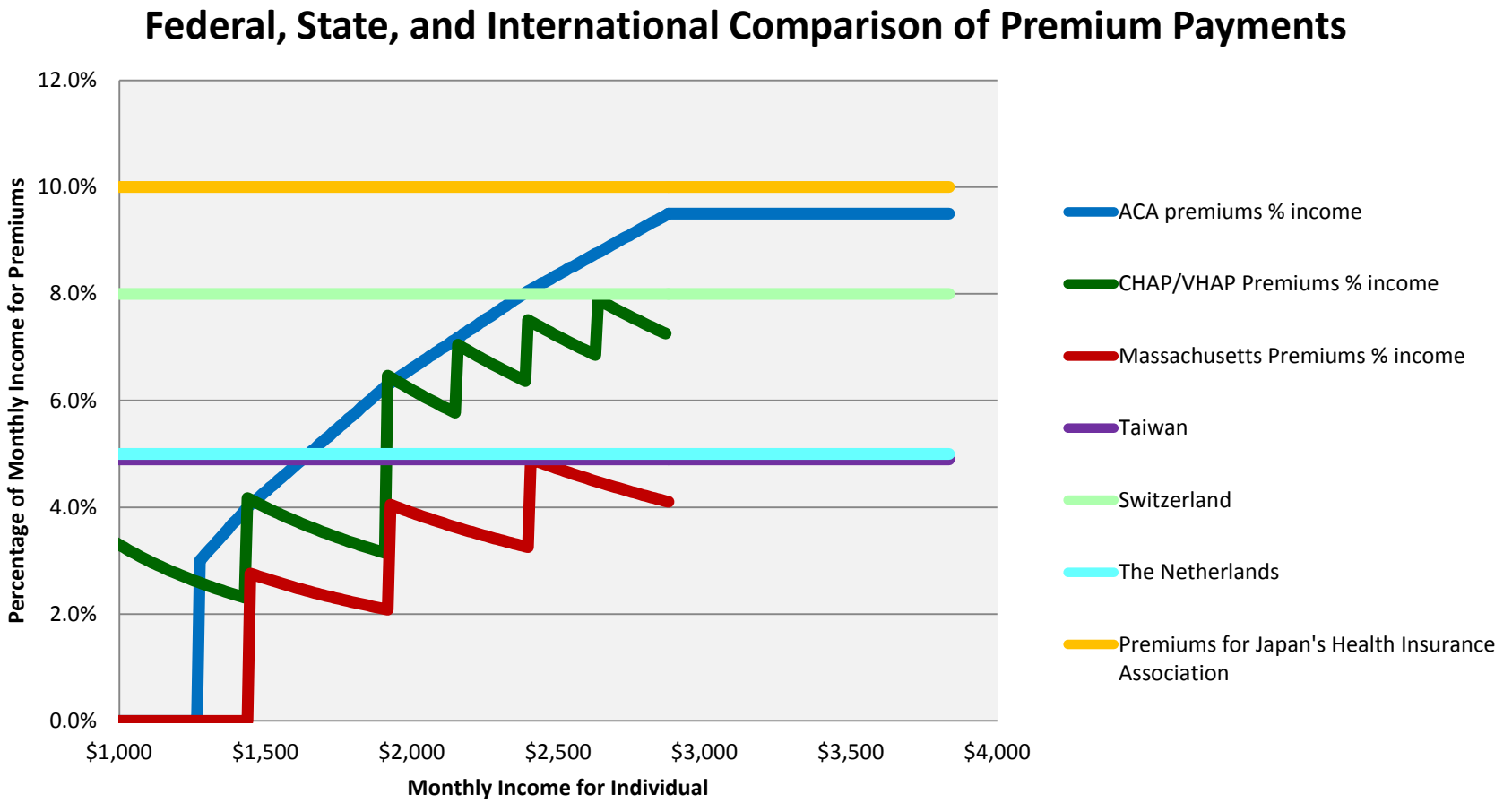
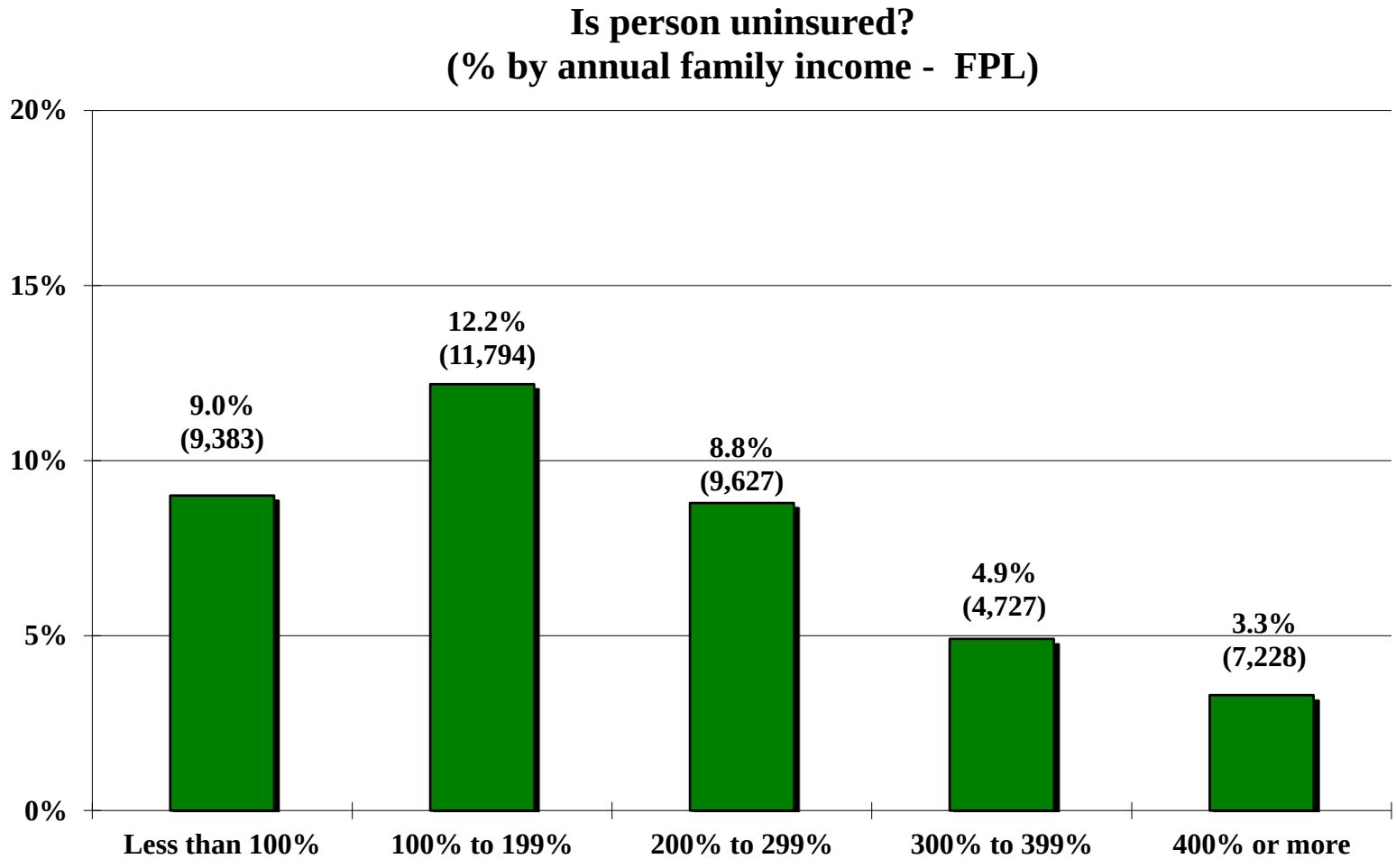


Background on Affordability Standards



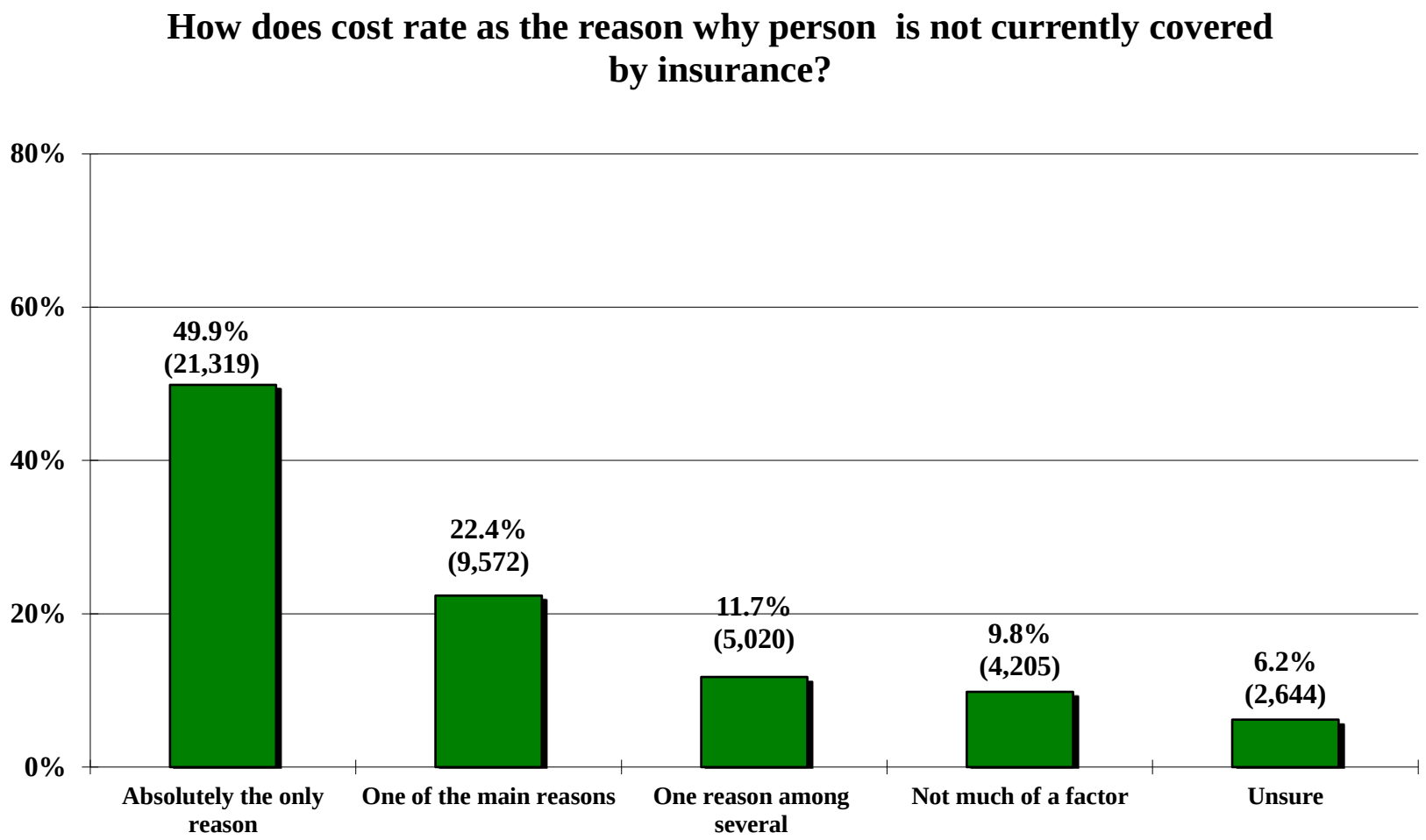
Note: International systems often have local or other forms of affordability assistance

Currently, the percentage of uninsured residents is largest among those whose family incomes are less than 400% of federal poverty level.



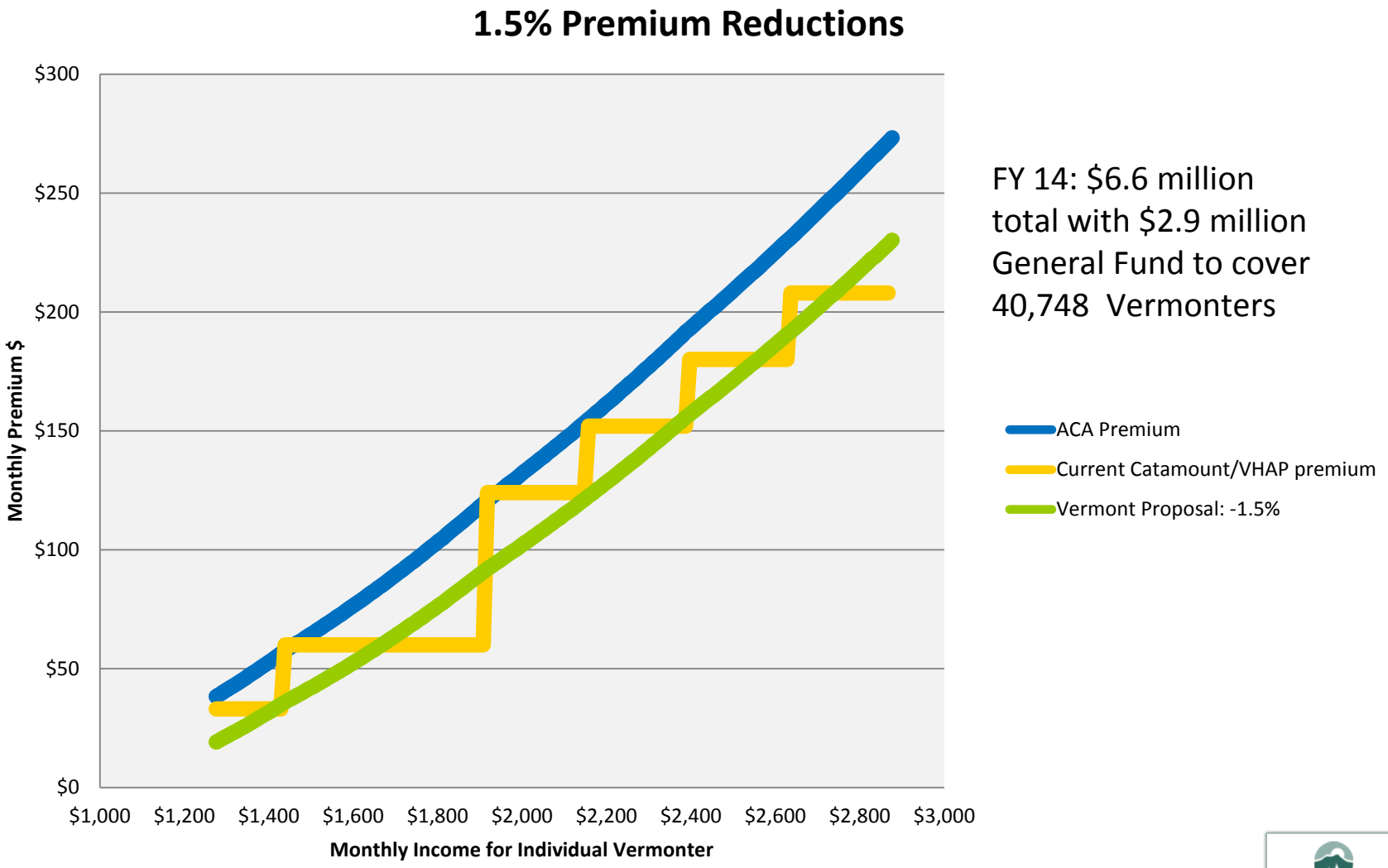
Data Source: 2012 Vermont Household Health Insurance Survey

Cost is the main reason uninsured Vermonters lack health insurance coverage.



Data Source: 2012 Vermont Household Health Insurance Survey

Premium Assistance Proposals

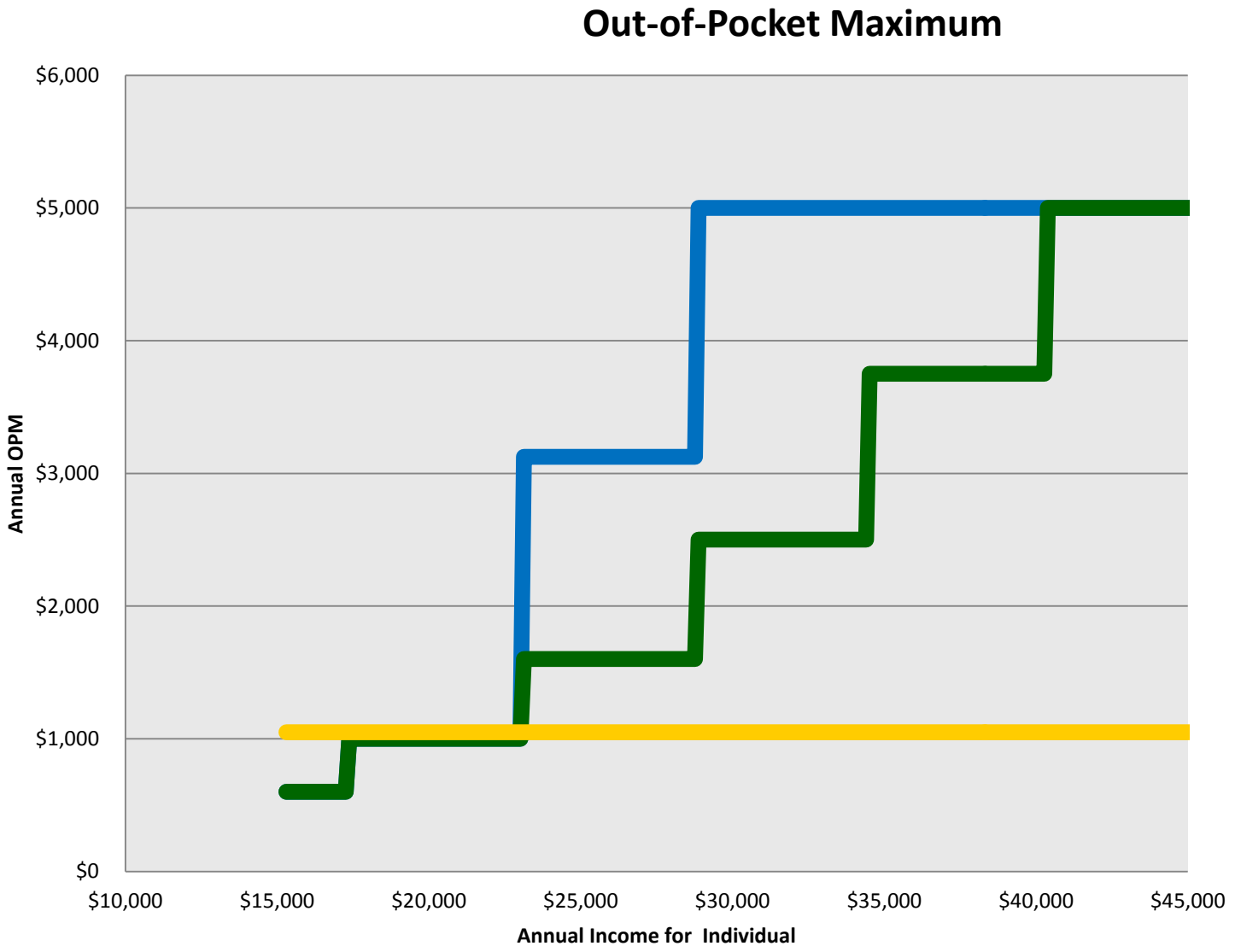


FY 14: $6.6 million total with $2.9 million General Fund to cover 40,748 Vermonters

Cost Sharing Assistance Proposal

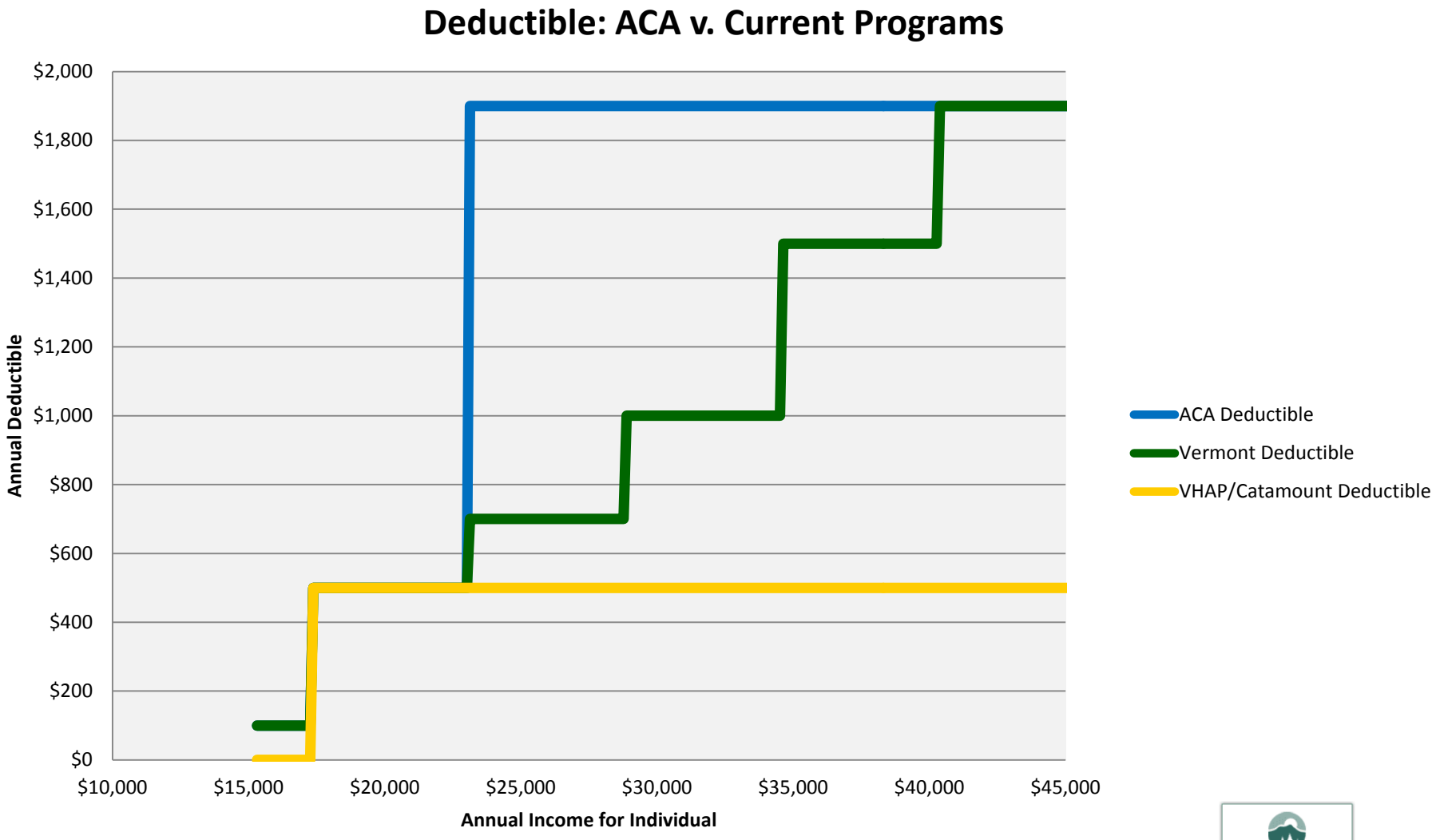
FPL%	ACA Cost Sharing AV	Vermont Proposed AV
100-150%	94%	94%
150-200%	87%	87%
200-250%	73%	83%
250-300%	70%	77%
300-350%	70%	73%

Cost Sharing Assistance Proposal



FY 14: $3.9 million total with $1.7 million General Fund to cover 44,954 Vermonters

Cost Sharing Assistance Proposal



Cost Sharing Assistance Proposal

	Deductible		
FPL	ACA	Current VT	Vermont Proposal
133-150%	$100	n/a	$100
150-200%	$500	$500	$500
200-250%	$1,900	$500	$700
250-300%	$1,900	$500	$1,000
300-350%	$1,900	$500	$1,500

	Out of Pocket Maximum		
FPL	ACA	Current VT	Vermont Proposal
133-150%	$600	n/a	$600
150-200%	$1,000	$1,050	$1,000
200-250%	$3,200	$1,050	$1,600
250-300%	$5,000	$1,050	$2,500
300-350%	$5,000	$1,050	$3,750

Primary care visits and other preventive medical services are covered without cost-sharing

2014 Financing Plan

- Vermont Health Connect Financing
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- Revenue Proposal

What is the cost-shift?

- The cost shift to Vermonters who buy private insurance is a hidden tax
  - Those who are privately insured cover underpayments from Medicaid, Medicare and uninsured Vermonters
  - Passed on through higher insurance rates to employers and individuals
  - Even Medicare budgets for inflation
- The cost shift from Medicaid - estimated to be >$183 million annually
  - just hospital and physician care
  - 9 percent of hospital budgets

Cost-Shift Proposal

- To address pressure on insurance premiums, implements an ongoing inflationary increase in Medicaid payments:
  - Roughly 3% increase starting October 1, 2013 (includes provider rate increase and budgeted utilization increase)
  - $24.4 million in FY 14 for rates, plus almost $10 million in utilization increase
  - Amending consensus budget process statute to require inflationary increases
  - Will reduce pressure on private insurance premiums by same amount
- Wherever possible, increase will be used to support payment reform moving away from fee for service
- Green Mountain Care Board can assure that this investment results in relief for private ratepayers, rather than increased health care costs

2014 Financing Plan

- Vermont Health Connect Financing
- Affordability
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- Funding Sources

Funding Sources: ACA Savings

- Reinvestment of ACA savings
  - results from migration of individuals from VHAP and Catamount to qualified health plans and from the 2.2 percent enhanced Medicaid federal match rate negotiated by Senator Leahy.
  - In addition, current revenues are expected to increase moderately due to inflation in health care spending and other factors.
- Increase the health care claims assessment by 1% over SFY 2015-2016
- Must address the Exchange funding this year to meet CMS requirements and obtain final approval of Exchange

Funding Sources: Claims Assessment

- A rate increase of one percent of paid claims
  - phased in over two fiscal years, half a percent of paid claims collected in each FY 2015 and FY 2016
- The claims assessment is the right source of revenue, because:
  - it does not disproportionately impact any one group of Vermonters over another,
  - it also does not negatively impact on the competitiveness of Vermonter employers,
  - it is connected to the Exchange, and
  - it is also one of the most common sources of Exchange funding chosen by other small states.

2017 FINANCING PLAN

2017 Financing Plan

- A plan to provide universal health care coverage to all residents, primarily through Green Mountain Care, beginning in 2017
- Consultants Retained:
  - University of Massachusetts Center for Health Law and Economics - a health policy consulting team
  - Wakely Consulting - an actuarial firm

UMass and Wakely were retained to:

- Estimate the likely covered population in 2014, by type of coverage, for all Vermonters, given changes resulting from implementation of the Affordable Care Act.
- Estimate the likely 2014 costs of coverage for health care for all Vermonters, given changes resulting from implementation of the Affordable Care Act.
- Estimate changes in types of coverage and costs of coverage from 2014 to 2017, required under Green Mountain Care in Act 48
- Examine the current distribution of cost burden of coverage on Vermonters and Vermont employers.
- Assess potential revenue sources to fund Green Mountain Care.

Health Reform Base Model 2017

- All Vermont residents will be enrolled automatically in Green Mountain Care (GMC)
- If individuals have other coverage (e.g. ESI or Medicare), the other coverage would pay first and GMC would supplement as needed ("GMC Secondary")
- GMC will provide comprehensive health care benefits, including:
  - comprehensive mental health and substance abuse services,
  - pharmaceuticals,
  - pediatric dental and vision care, and
  - care coordination
- GMC enrollees who meet Medicaid eligibility criteria will also be eligible for certain federally mandated services such as EPSDT, non-emergency transportation, and LTSS

Health Reform Base Model 2017

- The GMC plan has an actuarial value of 87%: Individuals, in aggregate, pay 13% of costs through copayments & deductibles
- Low-income individuals who are eligible for cost-sharing subsidies under the federal Affordable Care Act (ACA) also receive those subsidies in GMC.
- GMC pays health care providers 105% of Medicare rates.
- Administrative functions are provided by a unified system
- Additional options modeled separately: covered services, actuarial value, provider payment levels

Estimated GMC Base Costs 2017

Estimated health care costs under GMC in 2017, does not include administrative costs (in Millions)

GMC Primary (not eligible for Medicaid-match)	$1,519
GMC Primary - Medicaid-Match Eligible	$1,230
GMC Secondary – Medicaid-Match Eligible	$645
GMC Secondary - Medicare Primary	$83
GMC Secondary – ESI or Other Primary	$21
Total GMC Base Costs	$3,498

Additional Options Modeled

- Incremental savings/cost relative to Base Model:
  - Providers paid 100% Medicare Rates
  - Providers paid 110% Medicare rates
- Incremental savings/cost relative to Base Model:
  - Actuarial value 80% (plus ACA cost-sharing subsidies)
  - Actuarial value 100% (no out-of-pocket cost sharing)
- Incremental cost of additional benefits:
  - Adult dental (2 coverage levels modeled)
  - Adult vision
  - Comprehensive long-term services and supports (LTSS)

GMC Additional Options, 2017

- Estimated health care costs under GMC in 2017, does not include administrative costs (in Millions)
- These amounts cannot be simply added, the whole is greater than the sum of the parts

Provider payment rates: 100% Medicare	($113)
Provider payment rates: 110% Medicare	$113
Actuarial value 80%	($225)
Actuarial value 100% (no individual cost sharing)	$631
Adult Dental: Tier 1 Preventive (100%) & Tier 2 Restorative (80%)	$218
Adult Dental: Tier 1 Preventive (100%), Tier 2 Restorative (80%) & Tier 3 Major Services (50%)	$294
Adult Vision	$46
Comprehensive Long-Term Services & Supports (LTSS)	$917

Additional value provided by GMC in 2017

The $3.5 billion total cost of GMC includes:

- $77 million to cover the cost of the 12,128 individuals who would otherwise be uninsured in 2017
- $127 million to provide additional medical, pharmaceutical and dental benefits to 127,747 previously under-insured individuals
- $21 million to provide wrap coverage for 19,019 individuals who have ESI or other primary coverage
- $7 million to provide dental care to 21,736 children who would be uninsured for dental services without reform
- $1 million to provide vision care to 26,753 children who would be uninsured for vision services without reform
- $314 million to eliminate Medicaid cost-shifting, that is to bring Medicaid rates up to 105% of Medicare rates

Additional value provided by GMC in 2017

New benefit	Provided to	Number of individuals	Cost (millions)
Full health insurance coverage	Previously uninsured individuals	12,128	$77
Additional medical, pharmaceutical and dental benefits	Previously under-uninsured individuals	127,747	$127
Wrap coverage	Individuals who have ESI or other primary coverage	19,019	$21
Pediatric dental care	Children who were uninsured for dental	21,736	$7
Pediatric vision care	Children who were uninsured for vision	26,753	$1
Eliminate Medicaid cost-shifting (increase Medicaid rates to 105% Medicare rates)	Health care providers	NA	$314
TOTAL			$547

Total Statewide Health Care Costs, 2017

- Total cost includes GMC costs and non-GMC costs (Millions)
- With reform, all Vermonters have health insurance
- With reform, many Vermonters have access to more comprehensive benefits than without reform
- In 2017, claims cost (health care costs) are $87 million higher with health reform to pay for this additional care, and administrative costs are $122 million lower
- Net savings in year 1: $35 million

	Number of Individuals	Total Paid Claims Per Year	Admin-istrative Cost	Total Cost with Reform
Total cost without reform	636,244	$5,428	$523	$5,952
Total cost with reform	636,244	$5,515	$401	$5,916
Additional cost (savings)		$87	($122)	($35)

Total Statewide Health Care Costs, 2017-2019

- Single payer health reform is estimated to save $289 million over the first 3 years
- Conservative estimate of savings, just from creating single payer system

	2017	2018	2019	3 year total
Without reform	$5,952	$6,262	$6,606	$18,819
With reform	$5,916	$6,175	$6,448	$18,539
Savings with reform	$36	$86	$158	$281

Potential additional savings

- Hsiao identified additional savings that could accrue to the system over 5-10 years, not considered here
- Vermont will need to take additional steps to gain these savings; single payer system supports these efforts

	Option 1	Option 2	Option 3	Time frame
Reduced Fraud and Abuse	5.0%	5.0%	5.0%	5 years
Shift to Integrated Delivery System	10.0%	5.5%	10.0%	10 years
Medical Malpractice Reform	2.0%	2.0%	2.0%	5 years

Hsiao , Kappel & Gruber, Act 128 Health System Reform Design: Achieving Affordable Universal Health Care in Vermont, February 17, 2011, p.56.

Sources of Funds, 2017 (Millions)

- A new financing system will need to produce $1,611 million in funding that was previously paid by individuals and employers, a substantial reduction from the current system.

	Without reform	With reform	Difference
Individuals and Employers	$2,228	$332	($1,896)
Federal: Medicare	$1,613	$1,613	$0
Federal: Medicaid Match	$998	$1,247	$249
Federal: ACA	$267	$267	$0
Federal: Other	$209	$209	$0
State Medicaid Funding	$637	$637	$0
Total Sources of Funds	$5,952	$4,305	($1,647)
Total System Costs	($5,952)	($5,916)	$38
Amount to be Financed		($1,611)	($1,611)

Current financing

- Currently, Vermonters spend nearly $6 billion annually to finance the present health care system, including federal contributions.

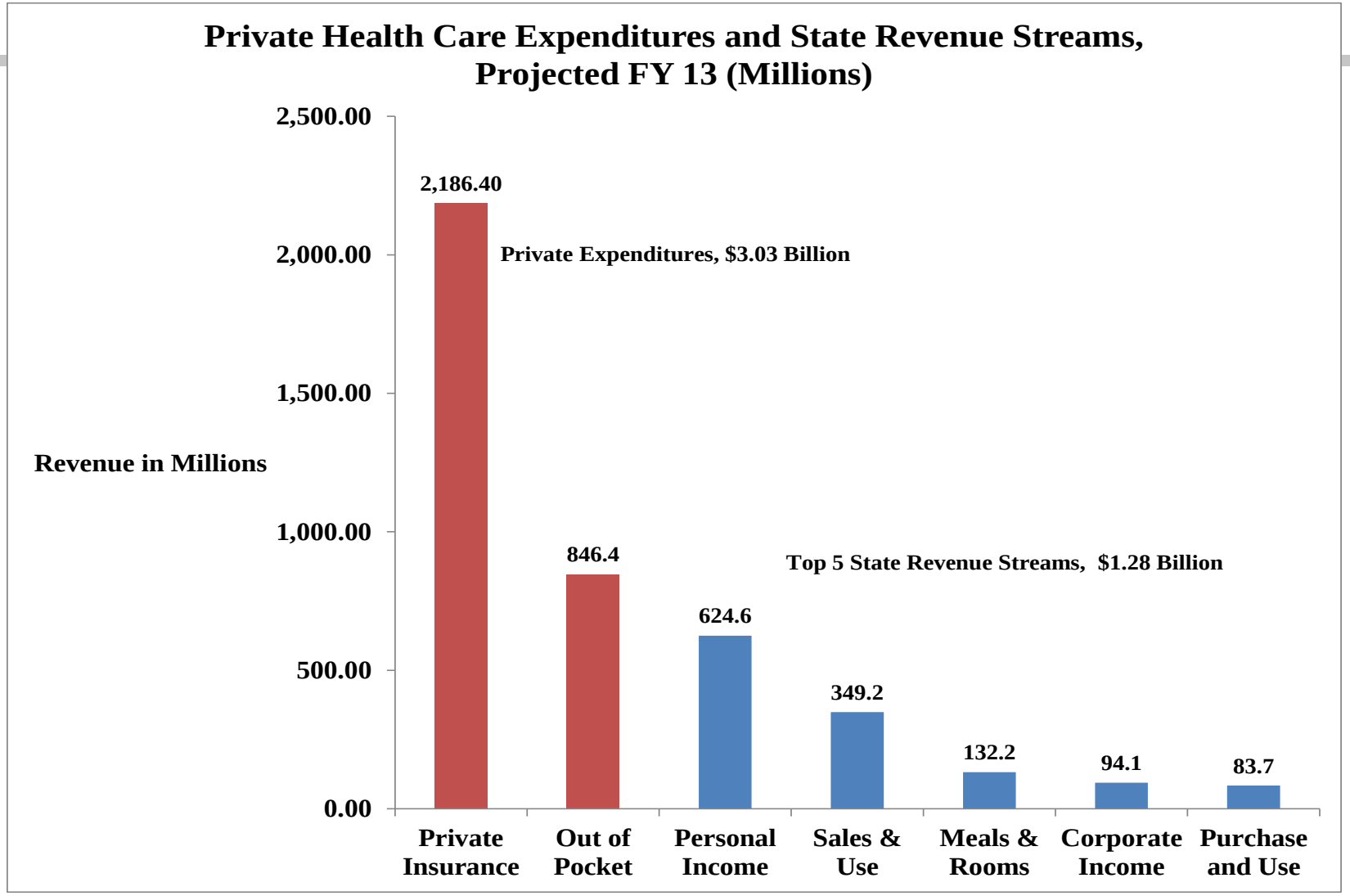
Contributing Group	Amount Spent on Health Care (Billions)
Out of Pocket	846.0
Private Insurance	2,186.4
Medicare & Medicaid	2659.2
Other Government	238.9
Total	**5,930.8**

Current financing

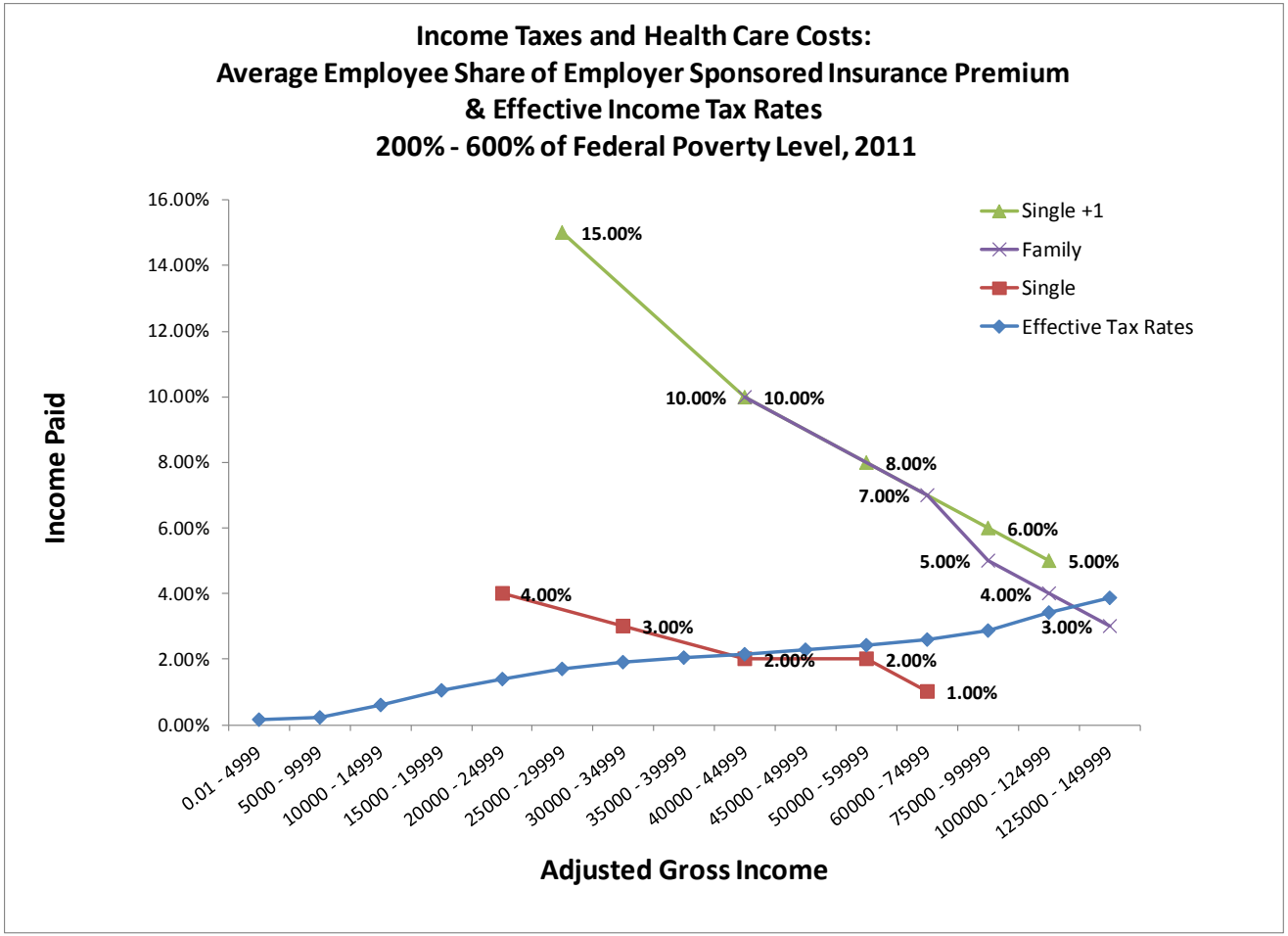
- Individuals and businesses make a substantial and regular contribution to health care.

Contributing Group	Amount Spent on Health Care
Employers	1,749.2
Individuals	1,283.7

- This contribution to the current health care system dwarfs Vermont's major revenue streams.


Private Health Care Expenditures and State Revenue Streams, Projected FY 13 (Millions)
Revenue in Millions
2,500.00
2,000.00
1,500.00
1,000.00
500.00
0.00
2,186.40
Private Expenditures, $3.03 Billion
846.4
624.6
349.2
132.2
94.1
83.7
Top 5 State Revenue Streams, $1.28 Billion
Private Insurance
Out of Pocket
Personal Income
Sales & Use
Meals & Rooms
Corporate Income
Purchase and Use

Current financing is inequitable



Future Financing Mechanism

- **Green Mountain Care will feature <u>a new funding source, not new funding.</u>**

- Policy debate should focus on redirecting the money Vermonters already spend.

- Paying less to cover more people with more valuable benefits.

Financing Considerations

- Consider relevant models
  - Current revenue system
  - Other states and the federal government
  - Other countries

- Consider current law policy choices
  - Tax expenditures as an example of opportunity

Revenue Sources

Revenue Source	FY 2013 Revenue (Forecast)	Tax Rate	Unit of Tax	New Revenue (Millions)
Payroll Tax	N/A	N/A	1%	119
Personal Income Tax	624.6	Various	1%	109
Sales and Use Tax	349.2	6%	1% Sales	58.2
Meals & Rooms (and Alcohol)	132.2	9% & 10%	1% Sales	14.6
Corporate Income Tax	94.1	Various	1% Surcharge	0.9
Purchase and Use	83.7	6%	1% Sales	14.0
Cigarettes & Tobacco	74.3	2.62 per pack	1 Penny	0.3
Gasoline	59.1	0.19	1 Penny per Gallon	3.2
Insurance Premium	59.3	Various	1% Value	29.2
Property Transfer Tax	28.3	Various	1% surcharge	0.3
Liquor	16.8	25%	1%	0.7
Diesel	15.6	0.25	1 Penny per Gallon	0.6
Bank Franchise	10.4	0.0096%	.0001% Increase	0.1

Current Tax Expenditures

Tax Type	Revenue Impact (2014 Estimated, Millions)
Sales and Use Tax	595.4
Income Tax (Federal Pass-Through)	289.9
Property Taxes	277.1
Personal Income Tax (State Level)	50.2
Purchase and Use	30.4
Insurance Premium	19.5
Gasoline & Diesel	13.2
Meals and Rooms	11.0
Corporate Income Tax	4. 39
Bank Franchise Tax	3.7
Total	1290.4

Financing Considerations

- Relationship between principles and funding sources
  - Equity
  - Affordability
  - Stability
  - Economic competativeness
- Impact of revenue sources
  - Incidence of revenue streams
  - Wage earner contributions v. non-wage earner contributions
  - What is the right mix of sources?
- Revenue streams influence behavior

Financing Considerations

- The ability of the financing sources to sustain your health care priorities over time
- The impacts and fairness of financing on individuals
- The impacts on the business and provider communities
- Engagement on these issues and policy principles

Feedback from Vermonters on health care financing principles