# State of Vermont

# Expansion of Health Insurance Coverage to Uninsured Vermonters

*Interim Final Report - REVISED*

**HRSA State Planning Grant**
**Report to the Secretary**

*October 29, 2001*

## The Vermont Agency of Human Services

**with assistance from:**
**The Lewin Group, Inc. and**
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**Supported by a grant from the Health Resources and Services Administration,**
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The views expressed in this report are those of the authors and do not necessarily reflect the views of other state agencies. Section Three represents work done outside the charge of the Steering Committee, and thus has not been endorsed by the Committee, yet is included in this report for its relevance to issues discussed.

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## EXECUTIVE SUMMARY

Since 1992, the State of Vermont has devoted significant resources to developing and implementing creative strategies for making health care coverage available to lower income uninsured residents. The purpose of this report is to describe the activities conducted to research the characteristics of uninsured Vermonters and the current state of the insurance, employer, and health care provider marketplaces in order to identify methods to extend coverage. Additionally, this report contains the findings of the research as well as a summary of the various options developed under the grant from the Health Resources and Services Administration (HRSA).

The Vermont Agency of Human Services (AHS) worked with The Lewin Group and Action Research to lead a broad coalition of public and private organizations in undertaking this work. A Steering Committee consisting of representatives from the various stakeholder groups met regularly and participated in planning and advising on the various research activities. During this period, a Family Health Insurance Survey was fielded by the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) which provided current information on the state's population demographics, including their insurance status.

> ...about 39 percent of the uninsured in Vermont (about 20,000 people) are actually eligible for Medicaid, VHAP or Dr. Dynasaur, but are not enrolled.

Qualitative and quantitative research were conducted to develop an in-depth understanding of the characteristics of the uninsured, as well as the basis for their uninsurance and their likely responses to various options and coverage strategies. The research process was iterative in that the findings from each activity informed the next. An early research finding was that other than adopting a single-payer model, there was no single option or program which could expand coverage to include all groups of the uninsured, and that multiple options needed exploration.

Focus groups and in-depth interviews were held with employers to identify and define the criteria they use to select insurance for their employees and determine their likely participation in coverage expansions. Focus groups were held with the uninsured to understand the factors that led to their being uninsured and to determine their willingness to pay for different health insurance benefit plans. Two workgroups composed of insurers and health care providers were held in which each group's perceptions of public and private health care coverage in the state were explored and coverage options were identified. Simulations were developed to model the cost and impact of each of the various options on each stakeholder group. Focus groups were then held with employers and uninsured Vermonters to market test the options. A tentative set of options was selected by the Steering Committee and modeled.

In a parallel effort, a Bipartisan Commission on Health Care Availability and Affordability appointed by the Governor in the winter of 2001 examined options for expanding coverage to uninsured Vermonters. Several Steering Committee members regularly attended these meetings. Additionally the HRSA project staff shared results and provided analytic support to this group.

## Characteristics of the Uninsured

During the course of this analysis, the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) conducted a survey of households to obtain information on health insurance coverage in the state. These data indicate that in 2000, there were 51,390 people without health insurance in the state (***Figure ES - 1***). This is equal to 8.4 percent of the state's population. About 69 percent of the uninsured indicated that they had been uninsured for over a year.

**Figure ES - 1**
**Comparative Distribution Across Age Groups**
**Uninsured Vs. All Vermont Residents, 2000**

| Age Group | Total Population | Uninsured Population | Percentage of Age Group Uninsured |
|---|---|---|---|
| **0-17** | 147,525 | 6,191 | 4.2% |
| **18-29** | 90,768 | 18,194 | 20.0% |
| **30-44** | 142,272 | 14,732 | 10.4% |
| **45-64** | 150,752 | 10,816 | 7.2% |
| **65+** | 77,512 | 1,457 | 1.9% |
| **Statewide** | **608,829** | **51,390** | **8.4%** |

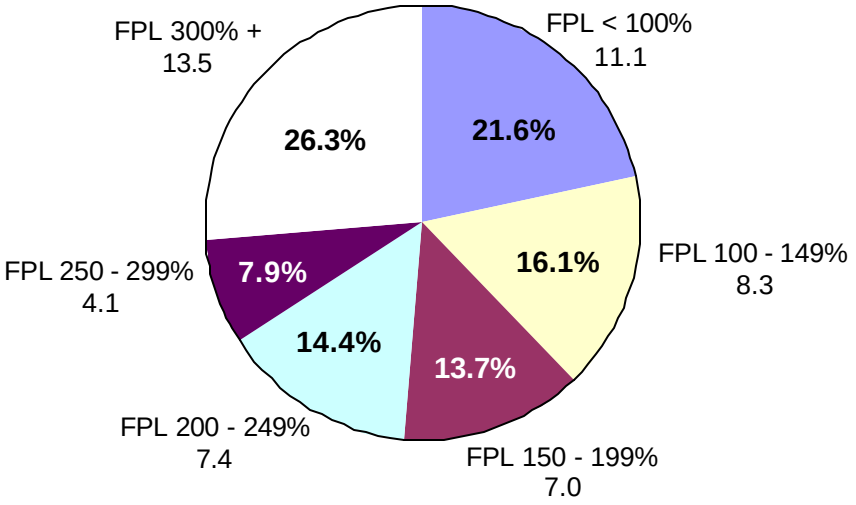
Source: Vermont Division of Health Care Administration, BISHCA 2000 VT Family Health Insurance Survey.

These data indicate that young adults have the highest concentration of uninsured people. About 20 percent of people age 18 to 29 were uninsured compared to 10.4 percent of adults age 30 to 44 and 7.2 percent for people age 45 - 64. Only about 4.2 percent of children are uninsured, which reflects recent expansions in eligibility for the Dr. Dynasaur program.

The uninsured are found at all income levels (***Figure ES-2***). About 51.4 percent of the uninsured are living below 200 percent of the Federal Poverty Level (FPL). Another 22.3 percent have incomes between 200 and 299 percent of the FPL while 26.3 percent have incomes in excess of 300 percent of the FPL. Based on these data, Lewin estimates that about 39 percent of the uninsured in Vermont (about 20,000 people) are actually eligible for Medicaid, VHAP, or Dr. Dynasaur but are not enrolled.

Two focus groups were conducted with uninsured Vermonters to better understand the reasons why some individuals and families go without insurance. All participants agreed that having health insurance is very important for themselves and for their families. Most had health insurance at one point in their lives but had lost it when they changed employers. Many reported they would enroll in a plan if they received a significant raise or went to work for an employer who offered health insurance. Many acknowledged that they are "gambling with their health" and are uneasy about being uninsured.

**Figure ES - 2**
**Distribution of the Vermont Uninsured by Federal Poverty Level, 2000**
**(in thousands)**




**Total Estimated Uninsured = 51.4**

Source: Vermont Division of Health Care Administration, BISHCA 2000 VT Family Health Insurance Survey.

Reasons for not having health insurance varied. The majority of participants lost their health insurance coverage because either they or a spouse changed jobs and were no longer offered health insurance as a benefit through an employer. Some participants are working at part-time or seasonal jobs, which do not offer health insurance. Several participants chose to leave their jobs to take care of family members at home; others were self-employed. The groups agreed that the main barrier to coverage the uninsured face is the cost of health insurance plans.

Personal health spending in Vermont was equal to about 12.7 percent of the state's Gross Domestic Product (GDP). This compares with 11.6 percent nationally and 12.2 percent in the New England states. Thus, despite the fact that per-capita spending in Vermont is less than in other states, health spending in Vermont comprises a larger share of state income (as measured by the state's GDP).

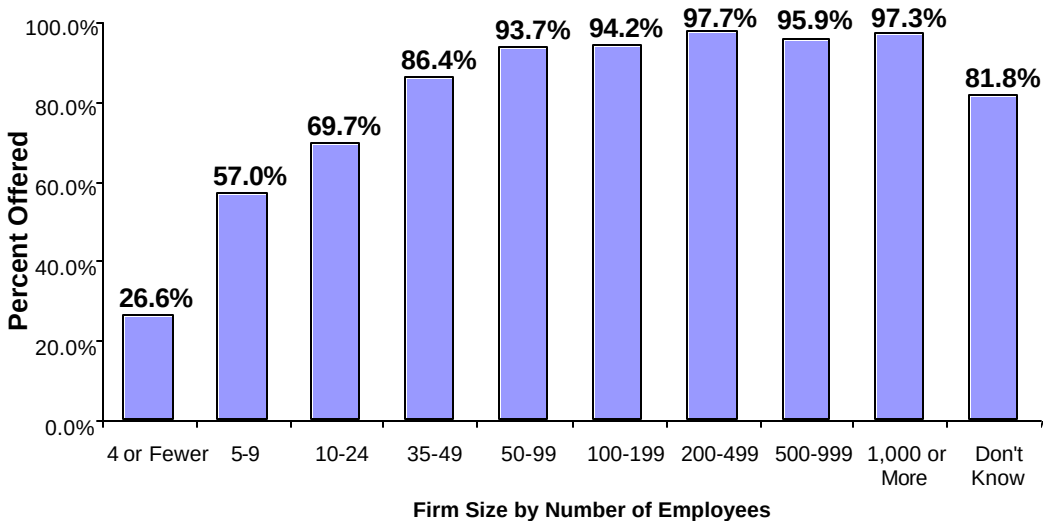
## Access to Employer-sponsored Coverage

According to the 2000 Vermont Family Health Insurance Survey, more than three-quarters of the uninsured population over the age of 18 are employed. Of these uninsured adults, about 66.5 percent were working full-time, 10.5 percent were working part-time, and 23.1 percent were not working for pay (i.e., homemakers, students, retirees and unemployed). These data suggest that programs to expand employer-sponsored coverage could have a significant impact on the state's uninsured.

People who work for employers that do not provide coverage tend to be in smaller firms. In 2000, the proportion of employees offered health insurance ranged from 26.6 percent in firms with fewer than 5 employees, to over 90 percent in firms with over 50 employees (***Figure ES - 3***). It should be noted however, that some of the workers in these firms do not take coverage

when offered, even if they have no other insurance, largely due to the cost of the coverage to the worker under these plans. Overall, about one-third of all uninsured working adults are employed in a firm with fewer than 5 workers.

**Figure ES - 3**
**Percentage of Workers Offered Health Insurance by Self-Reported Firm Size, Vermont Workers Age 18+, 2000**




Source: Vermont Division of Health Care Administration, BISHCA 2000 VT Family Health Insurance Survey.

Sixteen focus group sessions and 11 structured interviews were conducted with employers to gain their perspectives on health insurance. Employers who offer insurance reported being very happy to be able to do so, while most of those not offering it reported they would like to be able to do so. Employers who do not offer health insurance identified cost as the primary barrier to offering coverage including: premium levels, the unpredictability of costs in the future; and the time required to research and administer plans.

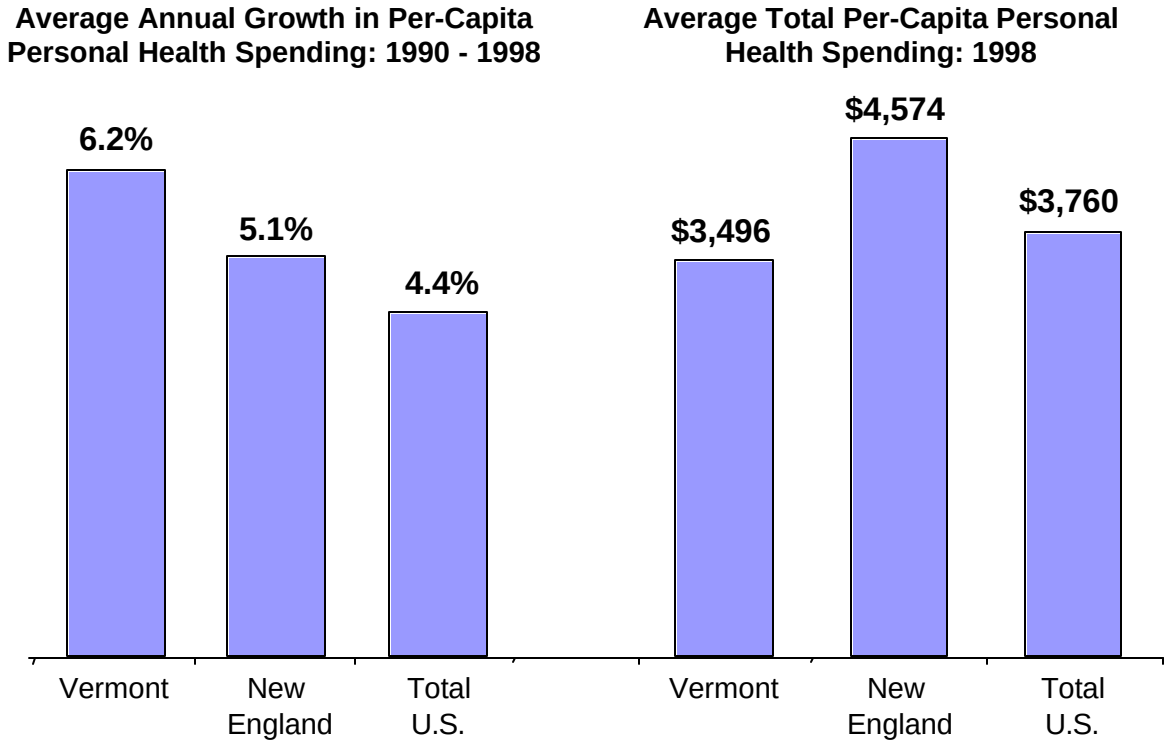
However, nearly all participating employers expressed significant frustration with the state of health insurance today. Participants feel that health insurance costs are completely "out of their control," and believe it is impossible to predict, plan or budget for annual health care expenditures. While most insuring employers plan to continue to offer coverage, many can foresee a time when they will need to significantly change the structure of the benefits they offer, whether by increasing the employee premium contribution, raising co-payments and deductibles, or reducing the benefits covered.

## Health Spending in Vermont

Per-capita health spending in Vermont is below the national average. Data from the Centers for Medicare and Medicaid Services (CMS) indicates that average total health spending per person in Vermont was $3,496 in 1998, compared with a national average of $3,760 (***Figure ES - 4***). Moreover, health spending in Vermont is generally below other states in New England. For

example per-capita health spending in the New England states was $4,574, which is about 30 percent higher than in Vermont (i.e., $3,496).

**Figure ES - 4**
**Per-Capita Personal Health Spending in Selected Geographical Regions: 1990 - 1998**




Source: Lewin Group analysis of the Centers for Medicare and Medicaid Services (CMS) State Health Expenditures data.

However, while health care costs in Vermont are low compared to other states, the state has experienced a higher rate of growth in health spending than other parts of the country. For example, per-capita spending in Vermont grew by an average of 6.2 percent per year, compared with a national average of only 5.1 percent, and an average of 4.4 percent across the New England states.

Based upon an evaluation of the available data for 1992 through 1999, the higher rate of growth in spending in Vermont appears to be attributed to the following:

? **Hospital Outpatient Utilization -** Utilization of hospital outpatient services increased by 8.9 percent per year compared to a national average of 4.5 percent.

? **Physician Expenditures -** Per-capita spending for physicians grew by 4.4 percent per year over this period compared with a national average of 2.9 percent.

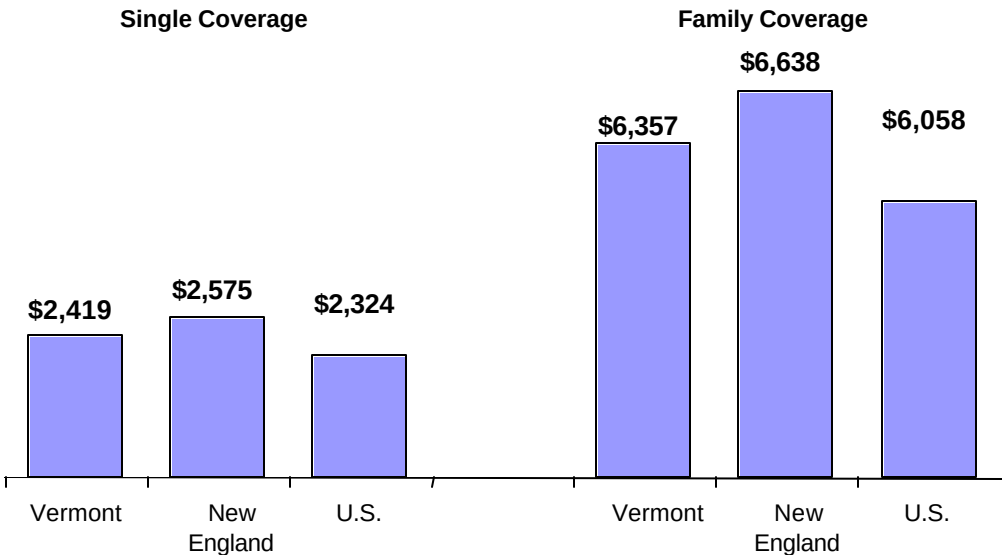
? **Reduction in the Number of Uninsured -** The percentage of Vermonters without insurance fell from 10.8 percent in 1993 to 8.4 percent in 2000, largely due to Medicaid/VHAP/Dr.

Dynasaur program expansions over this period. We would expect this to be associated with some increase in health spending.

? **Demographics -** Because Vermont includes a proportionally higher number of the baby-boom population, it has experienced a proportionally higher increase in spending as this population group ages. This effect on spending is expected to continue as the baby-boom population ages.

About 39 percent of health spending in Vermont is covered under private insurance, of which most is employer-sponsored coverage. The cost of employer-sponsored health benefits is lower than in other New England states. For example, data from the Agency for Healthcare Research and Quality (AHRQ) indicates that the average cost of employer coverage in Vermont (employee and employer share) in 1999 was $2,419 for single coverage and $6,357 for family coverage (***Figure ES - 5***). This is above the national average of $2,324 for single coverage and $6,058 for family coverage. However, Vermont spending for employer policies is less than the average for the New England states, of $2,575 for single coverage and $6,638 for family coverage.

**Figure ES - 5**
**Average Employer-Based Health Insurance Premium Costs Per Worker in 1999**




Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

## Competitive Environment

The state of Vermont has fewer insurers serving the individual and group markets than most other states. A nationwide study of health insurance markets found that in 1997, there were 15 insurers serving Vermont's group market (including small and large groups) and that 90 percent of the market were covered by just the three largest carriers in the state. By comparison, larger states typically had more insurers and a smaller concentration of enrollment in the largest plans. For example, Massachusetts had 55 insurers in the group market with only about 55 percent of the market concentrated among the largest plans. The study found that Vermont had fewer

carriers participating in both the group and the individual insurance markets than any of the other New England states. The number of insurers serving the group and individual markets has declined in Vermont since 1997, reflecting a general reduction in the number of health plans in these markets nationally.

The insurers Lewin interviewed during this project offered a number of opinions on why there are relatively fewer insurers operating in Vermont. However, the state's community rating and other regulatory policies were cited as only one of the reasons for this. They noted that there has been a general decline in the number of carriers competing in these markets nationwide, which is related to the large losses insurers have experienced in recent years. The state's small size also limits carrier interest in moving into the state.

However, one of the most important reasons suggested by insurers interviewed is that there is relatively little competition among health care providers in the state. For example, of the 14 hospitals in the state, 12 are the only hospital within 30 miles. This makes each hospital a monopoly in their market area, which contributes to the difficulty carriers have in negotiating favorable terms with the providers. This is crucial because insurers rely largely upon negotiated volume discounts with providers to make their premiums more price competitive. Thus, in today's insurance markets, competition among insurers is largely dependent upon the degree of competition among providers.

## Provider Capacity

One of the most important issues in this analysis is determining whether providers in Vermont would have the capacity to meet the increase in demand for health services that would be expected once universal coverage is achieved. In 1980, the Graduate Medical Education National Advisory (GMENAC) established standards of physician need for the population. Based upon these standards, Vermont's supply of physicians is probably adequate to marginal, although shortages do exist in parts of the state.

Vermont currently has about 186 patient care physicians per 100,000 people, which is below the estimated average of 215 for New England, but is above the estimated national average of 152 (***Figure ES - 6***). In addition, the state has an average of 39 dentists per 100,000 people compared with an estimated national average of 37 and an estimated average for New England of 45. The number of hospital beds per 100,000 people in Vermont (281) is less than the national average (303) but is close to the New England average. However, there are a number of areas in the state designated as Health Professional Shortage areas, which reflects a general mal-distribution of providers within the state.

Lewin estimates that universal coverage would result in an increase in utilization of physician and dental services of 3.7 percent and 4.3 percent respectively. Inpatient hospital utilization would increase by 0.7 percent, while hospital outpatient utilization (excluding emergency room care) would increase by 2.7 percent. Emergency room utilization would actually decline by about 0.9 percent. The cost of this increased utilization would be $23.6 million in 2002.

**Figure ES - 6**
**Physician Supply in Vermont, New England, and the United States per 100,000 People, 1999**

| State | Patient Care Physicians per 100,000 | Dentists per 100,000 | Hospital Beds per 100,000 |
|---|---|---|---|
| Vermont | 186 | 39 | 281 |
| New England [a/] | 215 | 45 | 259 |
| United States [a/] | 152 | 37 | 303 |

a/ Estimated.
Source: Estimates provided by the Vermont Department of Health and Lewin Group analysis of the 2001 Area Resource File.

That Vermont has more than the national average of physicians initially suggests that the Vermont health care system could absorb increases in utilization of this magnitude, however the poor distribution of providers within the state would continue to create access problems for many Vermonters.

## Cost Shifting

Cost shifting is the practice whereby providers recover the cost of uncompensated care and shortfalls in reimbursement under public programs by increasing prices for private payers. For example, Lewin estimates that payments to hospitals in Vermont under Medicaid and Medicare are equal to about 83 percent and 94 percent of costs respectively. These costs are passed-on to commercially insured people in the form of higher charges. For example, payments for commercially insured people in Vermont, most of whom are covered under employer plans, are projected to be 22 percent greater than costs for these patients. By comparison, payments for the commercially insured nationwide are on average about 13 percent greater than costs.

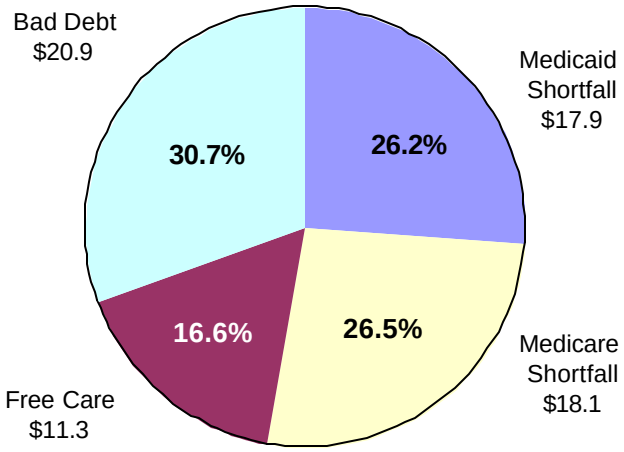
Lewin estimates that the amount of these shortfalls and the cost of charity care and bad debt will be $68.2 million for Vermont hospitals in 2001 (***Figure ES - 7***). However, Medicaid will account for only about 26.2 percent of the cost shift. About 26.5 percent will be attributed to shortfalls in Medicare reimbursement while the remaining 47.3 percent would be attributed to bad debt and charity care. Consequently, reducing the Medicaid cost shift would address only about a quarter of the hospital cost-shifting problem. In fact, eliminating the Medicaid hospital cost shift would reduce hospital payments for privately insured people by only about 3.6 percent.

## Options Studied

The options identified by the Steering Committee for consideration under the HRSA grant include:

? Outreach to increase enrollment in existing Medicaid/VHAP/Dr. Dynasaur programs. There are an estimated 20,000 people in Vermont who are eligible for Medicaid/VHAP/Dr. Dynasaur who have not enrolled, of whom 4,900 are children;

**Figure ES - 7**
**Hospital Cost Shift by Source of Shortfall in 2001 (in millions)**




**Total Hospital Cost Shift = $68.2 million**

Source: Lewin Group estimates.

? Income eligibility coverage expansion under VHAP to 300 percent of the FPL for all people including childless adults;

? Permit small employers and individuals living below 300 percent of the FPL to buy in to VHAP by paying a premium equal to the full actuarial cost of coverage. Enables eligible firms and individuals to take advantage of lower provider payment rates and administrative costs under VHAP;

? Buy-in to Employer coverage for Dr. Dynasaur children when cost-effective. The program would enroll eligible children of working parents with access to employer-sponsored coverage in the parent's plan by paying the employee's share of the family premium;

? Employer tax credits for small firms with low-income workers. The credit would be available to all firms with 25 or fewer workers and would be equal to 40 percent of what the employer spends for employee coverage;

? Low-cost coverage option for firms that have not provided insurance in the past 12 months. Creates a benefits package that is free of mandated benefits. Also provides a subsidy to eligible firms (in the form of reinsurance for high cost cases) that effectively reduces premium costs by 10 percent; and

? Single-payer program for Vermont.

Lewin evaluated these plans on the basis of their ability to close the gaps in coverage in the state. The BISCHA survey of households in Vermont indicates that about 91.6 percent of all people in the state have insurance coverage from some source. About 95.8 percent of children are covered

and about 90.2 percent of adults are covered. In addition, about 88.9 percent of Vermonters living below 300 percent of the FPL are insured.

All of the options considered would result in some reduction in the number of people without coverage. However, only the single-payer model would achieve universal coverage. Aside from the single-payer model, the options having the greatest potential impact on coverage were outreach programs to enroll people who are already eligible for VHAP or Dr. Dynasaur who have not yet enrolled. Lewin estimated that an aggressive outreach program could raise the coverage level for children to 97.5 percent and the coverage level for adults in the state to 91.8 percent. Under the outreach option, about 92.8 percent of all people living below 300 percent of the FPL would be covered.

Lewin's analysis indicates that higher levels of coverage could be achieved by combining certain policy options. For example, if the state were to adopt all of the VHAP expansion options discussed above (e.g., outreach with eligibility expansion for adults etc.) except the VHAP buy-in program, about 97.5 percent of children and about 93.6 percent of adults would be insured (***Figure ES - 8***). Adding the VHAP buy-in program would increase coverage for adults to 94.5 percent.

The state could also adopt a combination of the options designed to expand private insurance coverage. For example, providing the employer tax credit (40 percent credit for firms with fewer than 25 workers) together with the low-cost insurance product would increase coverage for both children and adults. However, coverage would reach only 96.7 percent among children and 91.1 percent among adults (***Figure ES - 9***).

Another approach would be to implement the full range of VHAP expansion and buy-in options together with the employer tax credit and the low cost insurance product. This scenario would reduce the number of uninsured by about 22,200 people, which is equal to about 43 percent of Vermont's uninsured population. Coverage under this combined policy would reach 98.0 percent among children and 95.3 percent among adults. Total state costs would be about $31.4 million, which is equal to about $1,400 per newly insured person.

## Direct Health Care Services for the Uninsured

An approach currently operating in Vermont and considered by the Steering Committee is a transitional model of direct "safety net" care designed to provide uninsured people with basic services until a stable source of insurance or financing is available. This service delivery approach of community-based care has been built upon the local commitment of specific health care organizations, their physicians and the community to assure access to health services by all in the community. The direct care model is best exemplified in the "free clinics" that have been established in various parts of Vermont and the Federally Qualified Health Centers (FQHCs) that provide care on a sliding fee scale.

## Figure ES - 8
## Summary of Cost and Coverage Impacts for Selected Coverage Expansion Options in Vermont

| | Number Enrolled | Reduction in Uninsured People | Net New State Costs (in millions) | Percentage of Children Covered | Percentage of Adults Covered | Percentage of People Below 300% FPL Who Are Insured | State Cost Per Enrollee | State Cost Per Newly Insured Person |
|---|---|---|---|---|---|---|---|---|
| **Current Coverage** | | | | | | | | |
| **Current Coverage Levels** | - - | - - | - - | 95.8% | 90.2% | 88.9% | - - | - - |
| **VHAP Expansion Options** | | | | | | | | |
| **Expand VHAP to Cover All Adults Through 300 Percent of the FPL** | 13,000 | 7,866 | $17.3 | 96.2% | 91.8% | 91.3% | $1,331 | $2,199 |
| **Outreach for Children's Coverage (assumes 50 percent effective)** | 2,457 | 2,457 | $0.7 | 97.5% | 90.2% | 89.7% | $203 | $203 |
| **Outreach for Adult Coverage (assumes 50 percent effective)** | 7,549 | 7,549 | $9.9 | 95.8% | 91.8% | 92.8% | $1,331 | $1,331 |
| **Buy-in to VHAP for Low-Wage Employers and People Below 300% of FPL** | 7,668 | 6,503 | $0.0 | 96.2% | 91.5% | 90.4% | $0 | $0 |
| **State Buy-in to Employer Coverage for Dr. Dynasaur Children** | 832 | 355 | ($0.1) | 96.0% | 90.2% | 89.1% | ($120) | ($391) |
| **Private Coverage Expansion Options** | | | | | | | | |
| **Employer Tax Credit for Non-insuring Firms with Fewer than 25 Workers Equal to 40 Percent of Employer Costs** | 6,700 | 4,416 | $5.0 | 96.5% | 90.9% | 90.0% | $746 | $1,132 |
| **Create Low-cost Insurance Option** | 4,050 | 4,050 | $0.9 | 96.4% | 91.0% | 89.5% | $222 | $222 |
| **Single-Payer Model** | | | | | | | | |
| **Basic Benefits Model** | 609,000 | 51,390 | $950.4 | 100.0% | 100.0% | 100.0% | $1,559 | $18,486 |

Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

## Figure ES - 9
## Summary of Cost and Coverage Impacts for Selected Combinations of Expansion Options in Vermont

| | Number Enrolled | Reduction in Uninsured People | Net New State Costs (in millions) | Percentage of Children Covered | Percentage of Adults Covered | Percentage of People Below 300% FPL Who Are Insured | State Cost Per Enrollee | State Cost Per Newly Insured Person |
|---|---|---|---|---|---|---|---|---|
| **Current Coverage** | | | | | | | | |
| **Current Coverage Levels** | - - | - - | - - | 95.8% | 90.2% | 88.9% | - - | - - |
| **VHAP Expansion Options** | | | | | | | | |
| **Expand VHAP to 300 Percent of FPL with Outreach for Currently Eligible Children and Adults** | 23,024 | 18,227 | $27.7 | 97.5% | 93.6% | 94.6% | $1,200 | $1,540 |
| **ALL VHAP Expansion Options with VHAP Buy-In** | | | | | | | | |
| **VHAP Buy-In** [a/] | 25,536 | 20,373 | $27.7 | 97.8% | 94.5% | 94.6% | $933 | $1,376 |
| **Combined Private Sector Options** | | | | | | | | |
| **Employer Tax Credit with Low Cost Insurance Product** | 7,510 | 5,226 | $5.8 | 96.7% | 91.1% | 89.9% | $772 | $1,110 |
| **All Public and Private Options Combined** | | | | | | | | |
| **All VHAP Expansions, VHAP Buy-In, Tax Credits and Low-Cost Product** | 29,199 | 22,160 | $31.4 | 98.0% | 95.3% | 94.7% | $1,075 | $1,380 |

a/ Due to the expansion in eligibility to 300 percent of the FPL, the buy-in would apply primarily to employers.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

The model emphasizes primary and preventive care and provides assistance when needed to access additional care such as specialty care or pharmacy services. In some examples of this approach, patients are integrated into on-going primary care and treatment systems. In other cases, services are provided at the free clinic sites. At FQHCs, comprehensive primary care is provided on a sliding fee scale basis to those without insurance.

This is not a formal "insurance" program, but providers agree to see patients based on local criteria and in free clinics, and have the right to refuse to provide some services or some individuals. There is no "out of area" coverage except as defined by referral arrangements with tertiary care centers. The “direct care model” does not replace existing insurance programs. The Legislature appropriated $300,000 in FY ’02 to help support the free clinics.

## Single-Payer

The single-payer system differs from incremental approaches in that it represents a fundamental restructuring of health care financing, moving from a mix of public and private funding to a universal, tax based financing system. It has significant implications for the private insurance market, current insurance and coverage arrangements, and offers the guarantee of universal coverage for all Vermont residents. This approach is discussed more completely in the full report.

## Recommendations

The Steering Committee met for a daylong session to make final selections of the options and reaffirm the coverage goals that had been implicit throughout the project. There was consensus on the goal of universal access to health insurance coverage for all Vermonters. The public and private sector strategies considered in the State Planning Grant process were primarily directed to people at or below 300 percent of the federal poverty level (FPL). The Steering Committee agreed on interim statewide coverage targets of 95 percent of adults and 97.5 percent of children.

Top criteria for rating the options included cost effectiveness, having identifiable revenue sources, increasing the number of people covered, being administratively simple, not shifting costs disproportionately, and being eligible for Federal matching funds. In addition, options should first focus on providing coverage to lower income Vermonters.

**The policy recommendations of the Steering Committee are presented below.**

### *1. In the short term Vermont should direct resources toward maintaining existing levels of coverage*

In Vermont, approximately 91.6 percent of all people have insurance coverage from some source. About 95.8 percent of children are covered and about 90.2 percent of adults are covered. Given the bleak short-term economic forecast, Vermont should focus its efforts toward maintaining this existing level of coverage.

*2. The target goal of 97.5 percent coverage of children can be met without new program initiatives. The Agency of Human Services should continue current outreach initiatives to eligible children not enrolled in Dr. Dynasaur*

The State could achieve the interim enrollment goal for children by increasing enrollment in existing programs, especially Dr. Dynasaur.

*3. Coverage should be expanded incrementally based on the State's financial capacity*

The Steering Committee's analyses identified that multiple incremental strategies will be necessary to make health insurance available to everyone. State initiatives should focus on uninsured Vermonters at or below 300 percent of the federal poverty level (FPL). Recommended statewide coverage targets for Vermont are defined as 95 percent of adults and 97.5 percent of children and could be reached through a multifaceted approach and a robust economy.

**In addition, the Steering Committee made the following recommendations to the Federal government.**

*1. Maintain the existing commitment of federal participation in 1115a waivers that have achieved coverage expansions*

The Vermont Health Access Plan (VHAP) is currently operating under an 1115a Medicaid Research and Demonstration Waiver approved by the federal government in 1995. It is recommended that the federal government (CMS) grant permanency to 1115a expansion populations by considering them part of the Medicaid spending base at the point of consideration of a new waiver, thereby eliminating the need to fund their ongoing coverage through savings under the budget neutrality provision of the 1115a waiver program.

*2. The Federal government should create additional tax incentives directed at small employers to encourage the provision of health insurance*

The most recent survey of the uninsured underscores that small employers are much less likely to offer health insurance than large employers. The Steering Committee recommends that the federal government use its tax authority to provide incentives to small businesses to cover their employees.

*3. Congress should establish a Medicare drug benefit*

Vermont and other states have established state programs to provide this essential coverage. Modernization of Medicare through the creation of a drug benefit would potentially make state resources available to either maintain existing initiatives for the uninsured or finance some of the coverage options identified in the Vermont State Planning Grant process.

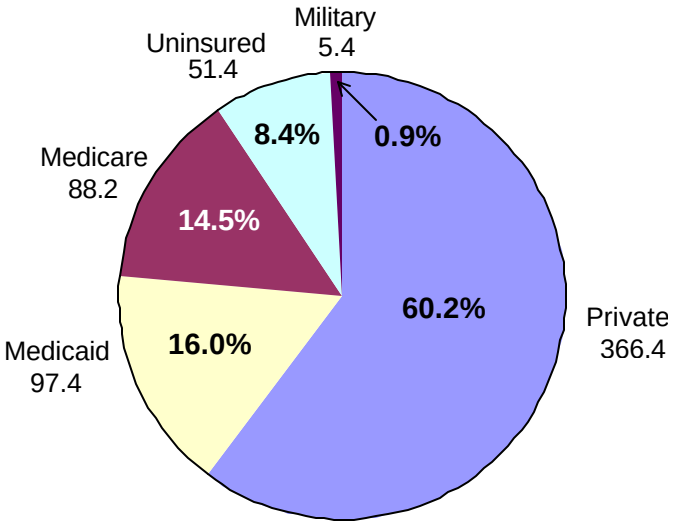
## SECTION ONE: UNINSURED INDIVIDUALS AND FAMILIES

This section presents baseline information regarding health insurance in the State of Vermont including a description of the characteristics of the uninsured. Information was obtained from three sources: (1) Vermont Division of Health Care Administration, (2) the Family Health Insurance Survey that was fielded in 2000 by the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), and (3) focus groups conducted with the uninsured by Action Research, Inc.

### A. Characteristics of the Uninsured

Out of a total of 608,828 people in Vermont (Census 2000), 51,390 are currently uninsured. Thus, approximately 8.4 percent of all Vermonters are uninsured compared to 14.3 percent nationally. Of those individuals who are insured, more than half (60.2 percent) are privately insured, 14.5 percent are insured by Medicare, 16.0 percent are insured by Medicaid, and less than 1.0 percent are insured by the military (includes dual eligibles) (***Figure 1***).

**Figure 1**
**Source of Health Insurance, All Vermont Residents, 2000 (thousands)**

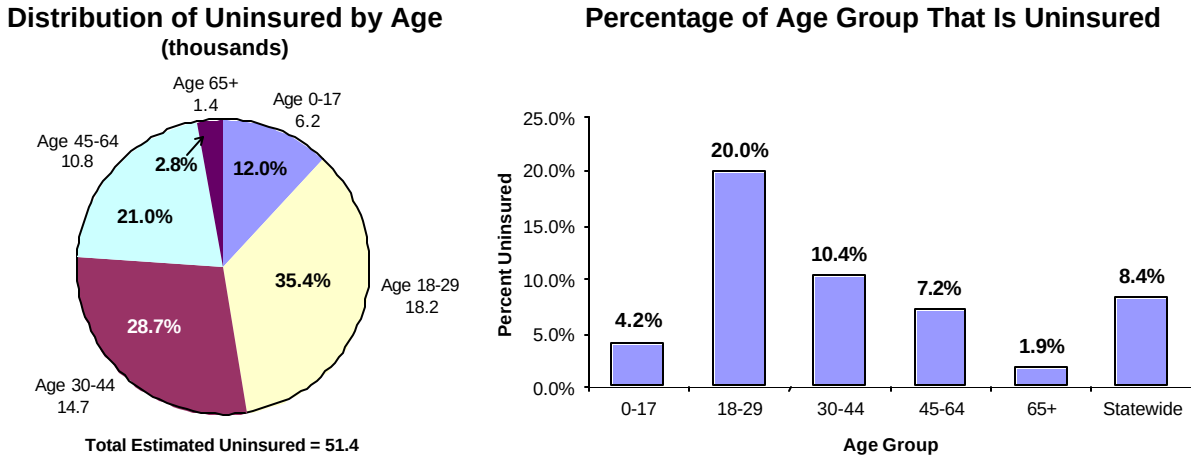



**Total Population=608.8**

Source: Vermont Division of Health Care Administration, BISHCA 2000 VT Family Health Insurance Survey.

***Figure 2*** (left-hand graph) summarizes the distribution of the uninsured in Vermont by age group. Individuals between the ages of 18 and 29 represented the largest percentage of the uninsured in Vermont (35.4 percent). Children comprise about 12 percent of the uninsured. Nearly all people age 65 and older are insured, primarily by Medicare.

**Figure 2**
**Age Characteristics of Vermont Uninsured, 2000**




Source: Vermont Division of Health Care Administration, BISHCA 2000 VT Family Health Insurance Survey.

The right-hand side of ***Figure 2*** shows the proportion of uninsured within each selected age group in Vermont. The highest rate of uninsurance, 20 percent, is among adults age 18-29, followed by adults age 30 to 44 at 10.4 percent. Vermont has generally been successful in its attempt to insure all children. Only about four percent of those aged 0-17 are currently uninsured. About 84 percent (4,129 individuals) of uninsured children are youths aged 6-17.

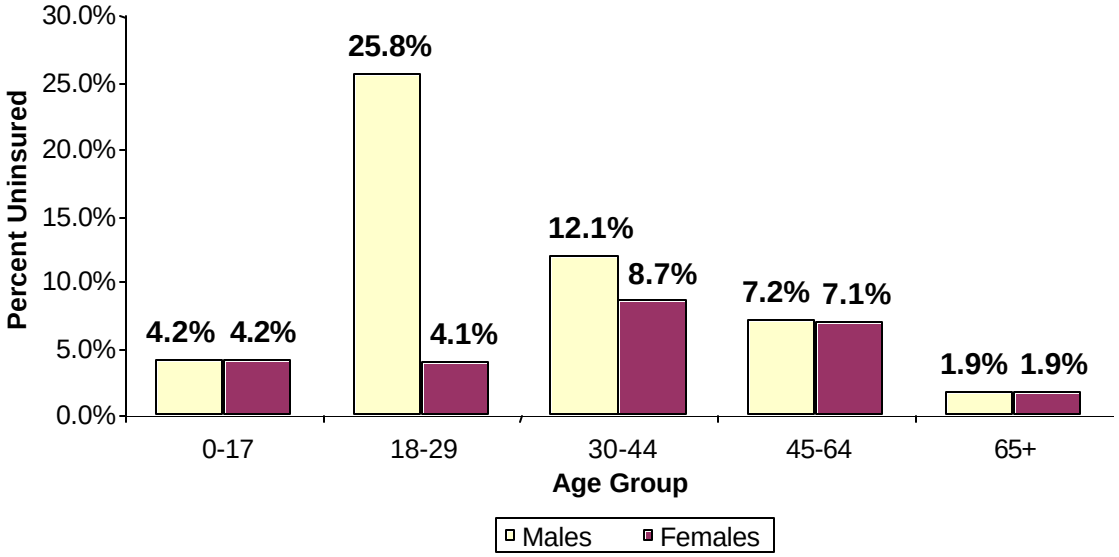
According to the 2000 BISHCA survey, 19,905 Vermonters (3.2 percent) identified themselves as Asian, African, American Indian or mixed race including those whose ethnicity is Hispanic. The rate of uninsurance among this group is 12.9 percent.

Vermont's population is 51 percent female and 49 percent male. The uninsurance rate for females is 7.0 percent and for males it is 9.9 percent. Among those aged 18 to 29, 25.8 percent of males and 14.1 percent of females are uninsured (***Figure 3***). For males aged 30-44, 12.1 percent are uninsured compared to 8.7 percent of females. The lower rate of uninsurance among women reflects the fact that the Medicaid program covers pregnant women.

In 2000, approximately 69 percent of the uninsured (about 35,500 people) reported having been uninsured for at least 12 months (***Figure 4***). Of the uninsured in Vermont, 14.2 percent did not have any health insurance for 6 to 11 months, 9.3 percent were uninsured for less than 3 months, and 5 percent were uninsured for 3 to 6 months. More than three quarters (77 percent) of uninsured adults 45-64 had been without health insurance for 12 months or longer. More than two-thirds (67 percent or 4,143) children aged 0-17 had been uninsured for at least one year.

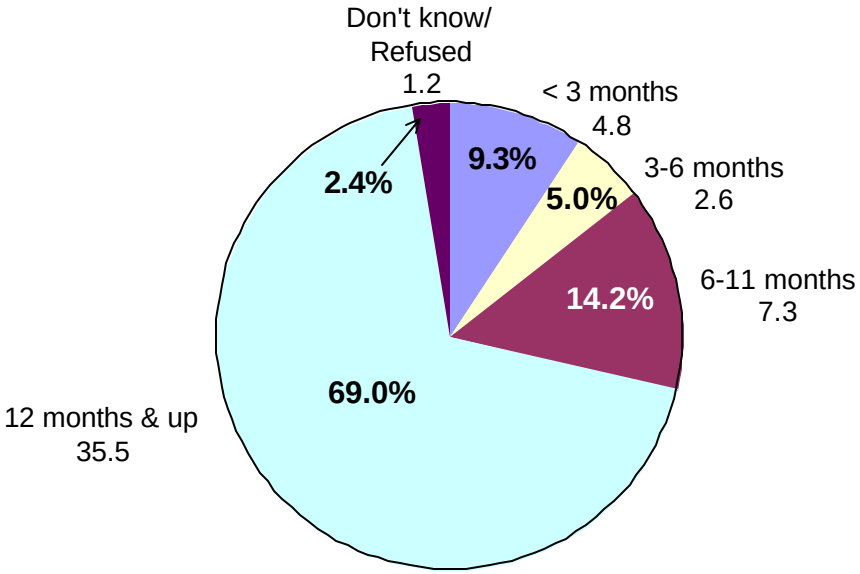
The uninsured were more likely to report themselves to be in fair to poor health than insured people. Among those with no health insurance, 11.7 percent reported their health status to be fair or poor as compared to 6.2 percent of people with health insurance (***Figure 5***). Only 42.5 percent of those who are uninsured ranked their own health as excellent as compared to 56.7 percent of those with health insurance.

**Figure 3**
**Uninsured Rate by Gender and Age, Vermont Residents, 2000**




Source: Vermont Division of Health Care Administration, BISHCA 2000 VT Family Health Insurance Survey.

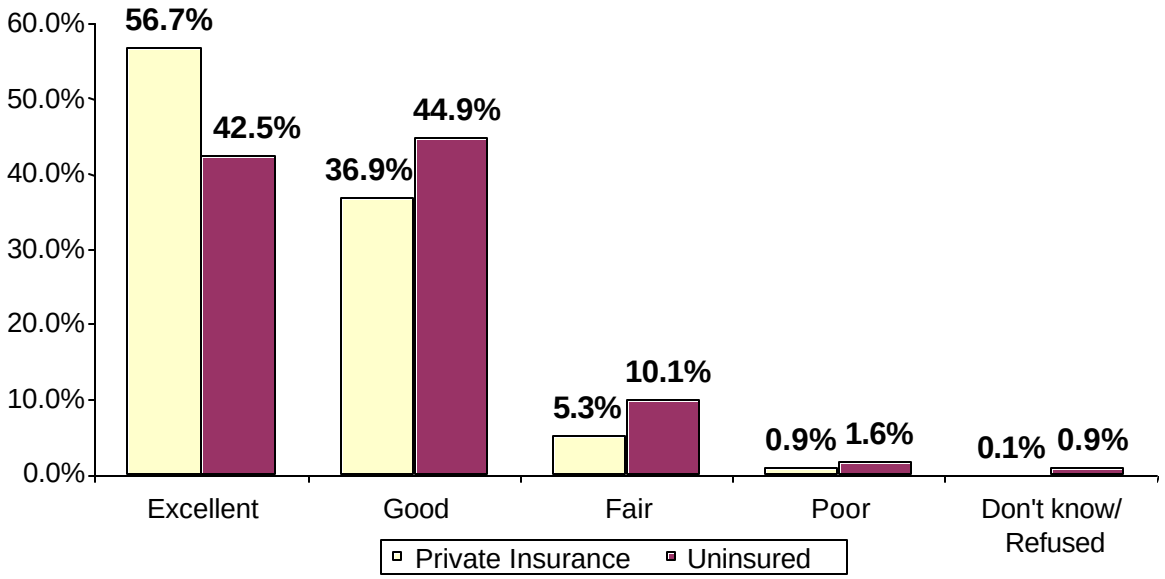
**Figure 4**
**Distribution of the Vermont Uninsurance by Duration of Uninsurance, 2000**
**(thousands)**




**Total Estimated Uninsured = 51.4**

Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

**Figure 5**
**Self-Reported Health Status Privately Insured vs. Uninsured Residents, 2000**



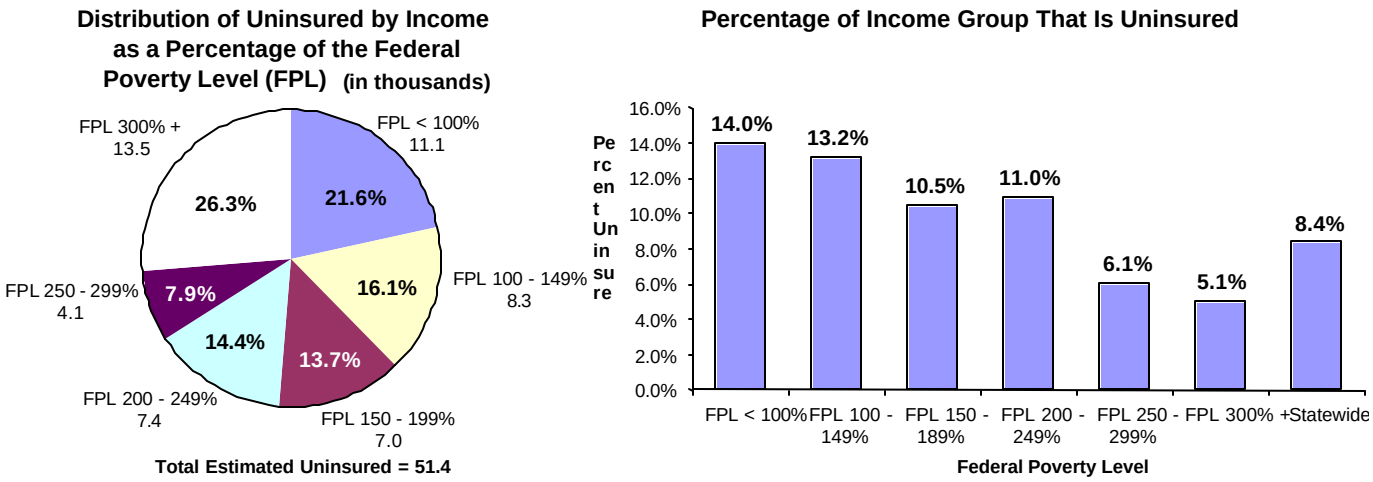

Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

The uninsured include people at all income levels. About 21.6 percent of the uninsured had incomes below the federal poverty level (FPL) (***Figure 6***). Another 29.6 percent had incomes between the FPL and 200 percent of the FPL, while another 22.3 percent had incomes between 200 percent and 300 percent of the FPL. About 26.3 percent of the uninsured had incomes greater than 300 percent of the FPL.

The percentage of people who are uninsured generally declines as income increases (***Figure 6***, right-hand side). The uninsured rate is highest for those below the 100 percent of the FPL (14.0 percent) and lowest for those with incomes above 300 percent of the FPL (5.1 percent). Above 250 percent of the FPL, the uninsured rate improves considerably. The wide distribution of uninsured across income groups suggests that a variety of approaches geared to different income levels may be needed to fully address the uninsured problem in Vermont.

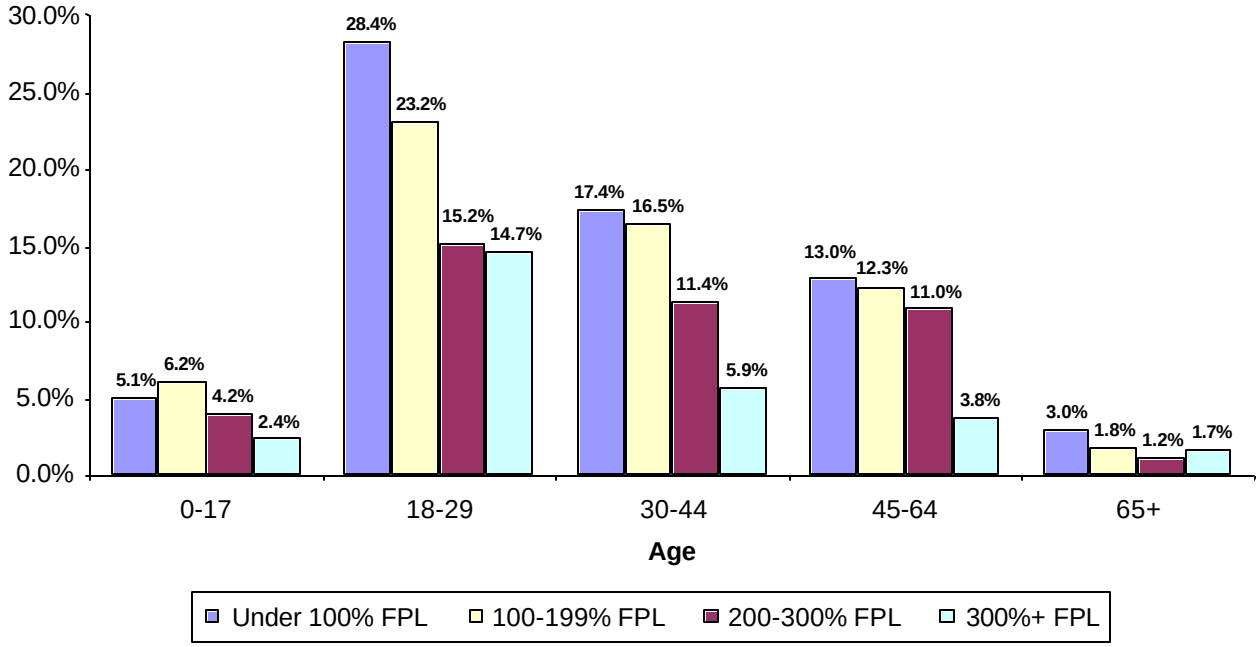
***Figure 7*** shows how coverage levels vary with income and age. Regardless of income level, younger adults are more likely to be uninsured than older adults. Higher income adults age 18-29 are about as likely to be uninsured as lower income adults who are older. Coverage levels increase with age at all income levels, which may be attributed to increased need for health care and with it a change in perception of the relative value of insurance The Steering Committee referred to these age groups as "young invincibles" (age 18-29), "Not so young, not so invincible" (age 30-44) and "not immortal after all" (age 45-64. Understanding this combination became extremely important in formulating and evaluating coverage options.

## Figure 6
## Income (as a Percentage of Federal Poverty Level) Characteristics of Vermont Uninsured, 2000




Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

## Figure 7
## Percentage of Age/Income Group Uninsured Vermont Residents, 2000

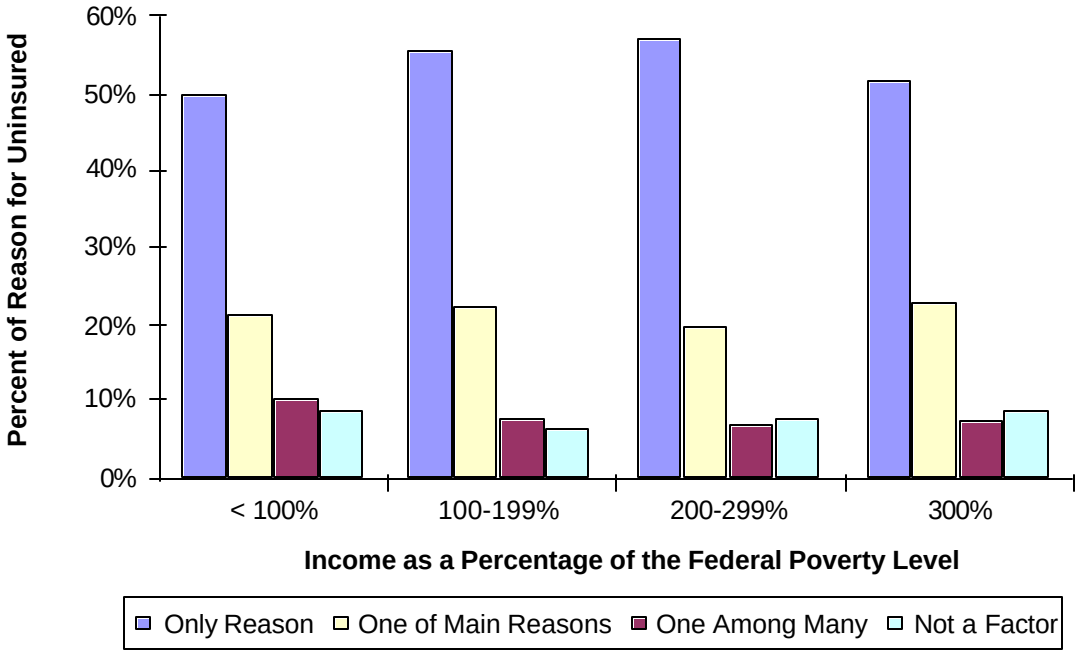



Source: Vermont Division of Health Care Administration, BISHCA 2000 VT Family Health Insurance Survey.

Costs are a significant barrier to care, particularly for the uninsured. At least 50 percent of the uninsured in Vermont, regardless of income, reported that cost was their only reason for being uninsured in 2000 (***Figure 8***). Another 25 percent reported that cost was their main reason for

being uninsured. Fewer than 10 percent of the uninsured in Vermont reported that cost was not a factor for being uninsured. It is of particular interest that those with incomes over 300 percent of the Federal Poverty Level are as likely to cite cost as a factor in being uninsured as those with incomes less than 100 percent of the Federal Poverty Level.

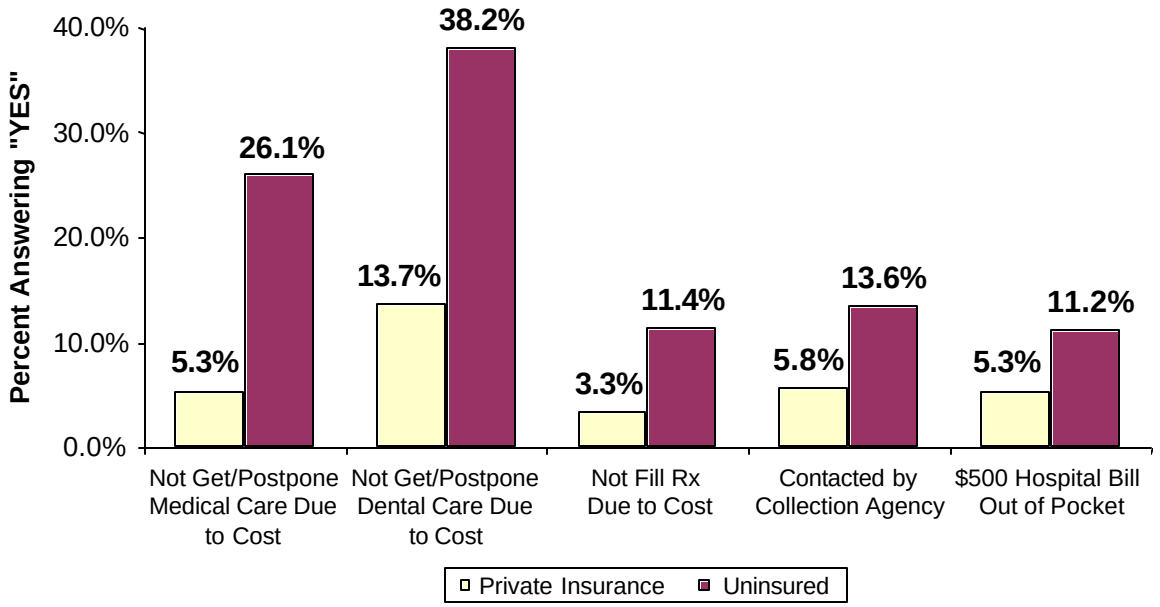
**Figure 8**
**Cost as the Reason for Being Uninsured by Federal Poverty Level, Uninsured Vermont Residents, 2000**




Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

Approximately 26.1 percent of the uninsured reported that they either did not get medical care or postponed medical care due to cost barriers compared to 5.3 percent of the privately insured (***Figure 9***). An even greater proportion of the uninsured reported that they would either not get or would postpone dental care due to cost barriers. About 38.2 percent of the uninsured reported that they did not get dental care or postponed dental care due to costs compared to 13.7 percent of the privately insured. A larger share of the uninsured also did not get a refill on their prescriptions due to costs. Many of the uninsured also reported they were contacted by a collection agency about their medical bills, and that they had hospital out-of-pocket expenses in the amount of $500.

**Figure 9**
**Cost Barriers to Care, Privately Insured vs. Uninsured Residents, 2000**




Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

## B. Focus Group Findings

Focus groups are useful in exploring attitudes and preferences that cannot be revealed through survey research. Two focus groups were conducted with uninsured Vermonters in order to determine why individuals were uninsured and how much they would be willing to pay to have coverage. Additionally, participants' views on how to expand coverage were elicited in these groups. Later in the project, two additional focus groups were conducted with uninsured Vermonters to market test the coverage options that had been developed. In these groups, three plans were discussed in-depth: Medicaid Eligibility Expansion, the Direct Care Model and the VHAP Buy-In to Employer-Sponsored Health Plans. The Employer Health Insurance Tax Credit and the Low-Cost Insurance Plan were also briefly discussed. The focus group reports for both groups are contained in ***Appendix D***.

### *1. Importance of Health Insurance*

All focus group participants agreed that having health insurance is very important for themselves and for their families. Many reported they would enroll in a plan if they received a significant raise or went to work for an employer who offered health insurance.

Most participants mentioned that not having health insurance made them uneasy; they worried about what might happen if they were ill or injured. Many acknowledged that they are "gambling with their health." For example, some participants mentioned that they participated in physically demanding jobs, such as landscaping or construction and noted that if they were injured during these activities they would be forced to pay the full cost of their care to a hospital or private physician.

The top five reasons mentioned in the BISHCA survey for not having health insurance were: Cannot afford it (49 percent), Do not qualify for government programs (18 percent), Unsure (9 percent), Employer doesn't offer (7 percent) and, "Lack of information" (5 percent). Reasons for not having health insurance also varied among focus group participants. The majority of participants lost their health insurance coverage because either they or a spouse changed jobs and were no longer offered health insurance as a benefit through an employer. Some participants are working at part-time or seasonal jobs, which do not offer health insurance. Several participants chose to leave their jobs to take care of family members at home; others were self-employed. The cost of purchasing health insurance on their own was cited by nearly all as the reason they are currently uninsured.

Some questioned the "value" of health insurance, citing the relatively high cost compared to what they perceive that they need. Many felt it was more cost-effective to pay when they actually use the service. Others expressed the desire to have a “cafeteria style” plan available so they could select the services that they want and not bother with the rest. A few prefer to use “alternative” providers that are not covered by traditional insurance plans.

### *2. Cost of Health Insurance*

In the BISHCA survey, 75 percent of people without insurance cited cost as the only or main reason for being uninsured. This was supported in the focus groups, where the main barrier also cited was the cost of health insurance plans. The majority of participants are not offered health insurance through their employers and believe they can not afford to buy it privately. Most indicated that premiums above $100 or $150 a month would be too much for them to pay. They feel that a basic plan, with a $1,000 to $2,500 deductible would cost about $300 a month.

Additionally, other expenses such as co-pays and deductibles have a significant role in how much participants are willing or able to pay for insurance. Participants believe that it is less expensive for them pay out-of-pocket for health services than if they were to pay a monthly insurance premium. They feel that if anything major were to happen, they would work out a time-payment plan with the provider.

### *3. Source of Medical Care*

When medical care is needed, focus group participants generally prefer to go to a clinic in their area that offers free or sliding-scale fees for service. Participants indicated that without these clinics, many of the uninsured would not have access to health care or would utilize emergency rooms more often. Several participants said they prefer to seek treatment with private health care providers they know, turning to a clinic only if necessary. They generally do not seek out preventative care, often delay seeking medical care when needed, and have little continuity of care with a single provider.

### *4. Public Insurance Programs*

While these questions were not addressed directly in the focus groups or survey, anecdotal information indicates many of the same reasons for not participating in public programs as in

private: people are unaware that they are eligible and/or may not feel they need health insurance. For the public programs with co-pays, the cost of participation may still be unaffordable or a lower priority expense than other needs. Because some public programs have retroactive benefits, there is little incentive to maintain continuous coverage.

### *5. Who Should Be Responsible*

Most participants believe that the government and employers should be responsible for providing health insurance to Vermonters. However, many participants were wary of a government-only system such as the Canadian-style single-payer program.

### *6. Participant Recommendations for Expanding Coverage*

Participants had a wide variety of recommendations for extending health insurance coverage to more Vermonters. Many of the recommendations include shared responsibility between the state, employers and insurance companies. Many participants recommended expanding the eligibility of existing state-funded health insurance programs. Participants believe this will allow more people to participate in health insurance programs. Participants also recommended the state consider each case individually, taking into account possible mortgage and car payments when looking at income caps.

Participants indicated that the minimum benefit for basic health plan should be coverage of annual physicals, sick doctor visits, prescription drug coverage, emergency care and hospital stays. A few participants stated that annual dental visits and routine dental work also should be covered, and some noted that they would like to see rehabilitation, home health and alternative medical care covered.

### *7. Impact of Subsidies, Tax Credits or Other Incentives*

Participants in both the initial focus groups and the second round (that considered the various options for expanded coverage) provided some information regarding the probable value of various incentives to insurance coverage. Given the strong influence of total cost and perceived value of health insurance, few of these options can be expected to significantly increase the number of insured.

With all of the options, focus group participants expressed concerns about “red tape”, complicated applications, and inflexible eligibility standards. There appeared to be a consensus that any subsidy or incentive be “fair”. This led to less support for options that targeted sub-groups such as employers that do not currently offer insurance, and more support for broad based options such as expansion of Medicaid to all with incomes less than a set amount. Participants were aware of the cost-shift that occurs when public programs pay less than private for services and were wary of expanding public programs without addressing this problem. There was little support for a low-cost insurance option. The single-payer option elicited strong concerns about costs (increased taxes), quality, choice and an expanded government role in health care.

## SECTION TWO EMPLOYER-BASED COVERAGE

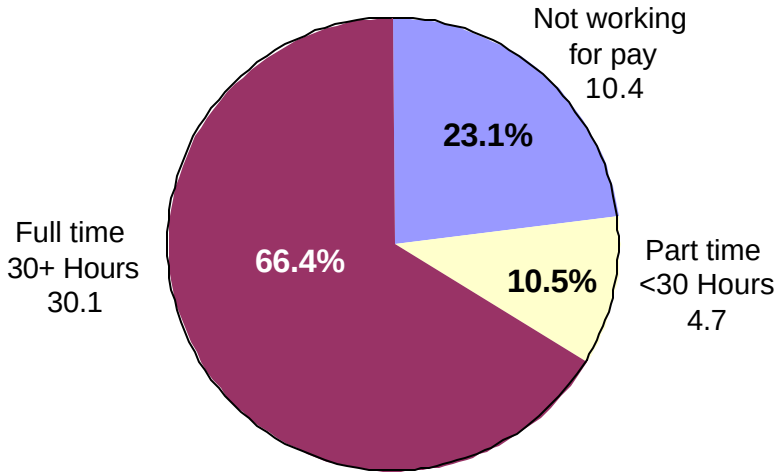
The purpose of this section is to discuss the status of employer-based coverage in Vermont. The bulk of Americans and their families obtain coverage through the workplace, making employers the cornerstones of private health coverage in the United States. It is important, therefore, to gain an understanding from employers about the health insurance they offer in Vermont. This also gives us a basis for designing policy options and effective workplace strategies to expand coverage in Vermont.

There are two major areas covered in this section. First, Lewin provides an overview of employer coverage in Vermont. A discussion of the focus group and key informant interviews is then presented. In this discussion, the factors that influence employers' decisions on whether or not to offer health insurance to their employees are discussed. Employers' ideas regarding possible ways to expand health insurance coverage in Vermont were also obtained.

### A. Employer Coverage

According to the 2000 Vermont Family Health Insurance Survey, more than three-quarters of the uninsured population over the age of 18 were employed at the time the survey was fielded in 2000 (***Figure 10***). Out of these uninsured individuals over the age of 18, 66.5 percent were working full-time, 10.5 percent were working part-time, and 23.1 percent were not working for pay (i.e., homemakers, students, retirees, and unemployed).

**Figure 10**
**Distribution of the Vermont Uninsured Aged 18+ by Employment Status, Main Job 2000 (thousands)**

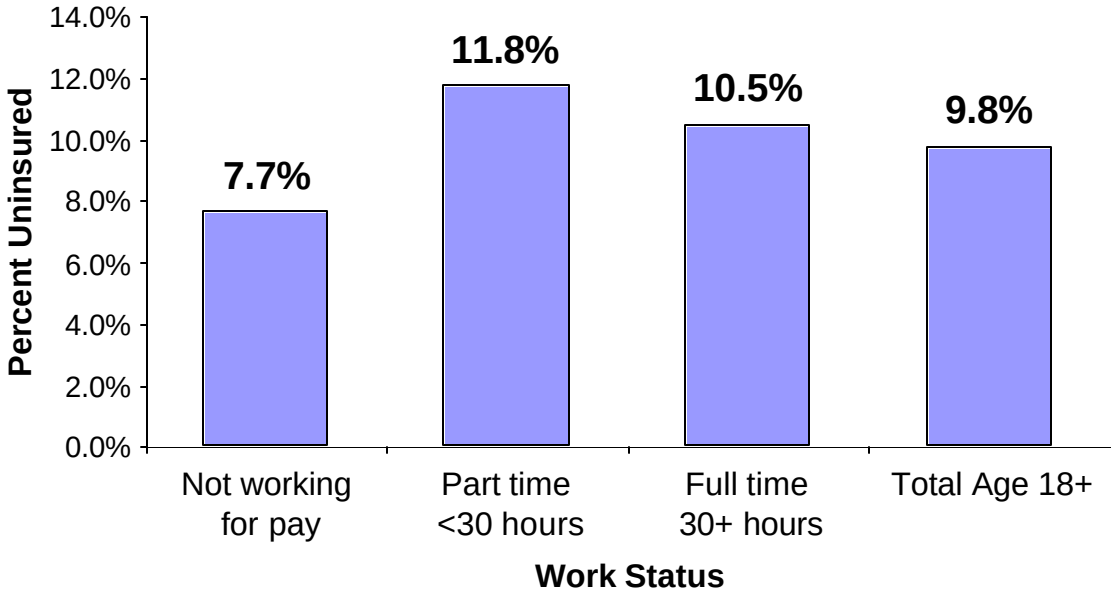



**Total Estimated Uninsured Aged 18+ = 45.2**

Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

In 2000, almost 10 percent of individuals age 18 and over were uninsured in Vermont (***Figure 11***). Approximately 11.8 percent of part-time employees age 18 and over in Vermont were uninsured compared to 10.5 percent of individuals who worked full-time. Those individuals age 18 and over, who were not working for pay (i.e., homemakers, students, retirees, and unemployed) represented the smallest percentage of the uninsured (7.7 percent).

**Figure 11**
**Uninsured Rate by Work Status, Hours Worked at Main Job, Vermont Residents Aged 18+, 2000**

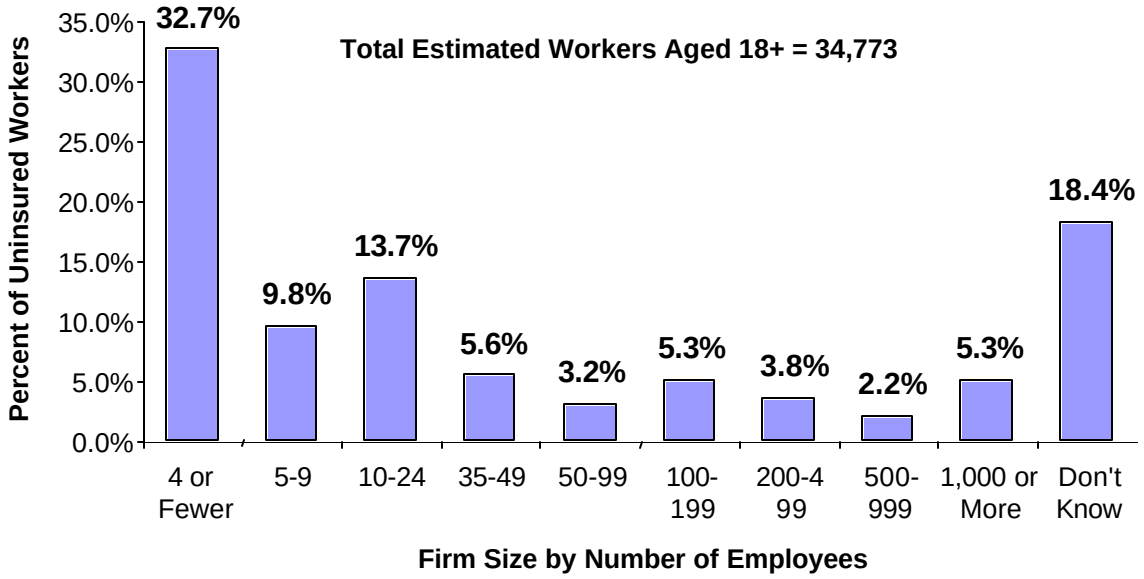



Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

Nearly one-third of uninsured workers reported that they worked for firms with fewer than 5 employees (***Figure 12***). Another 32 percent of uninsured workers are in firms with 5 to 50 employees. Only about 3.3 percent of uninsured workers are in firms with 1,000 or more workers.

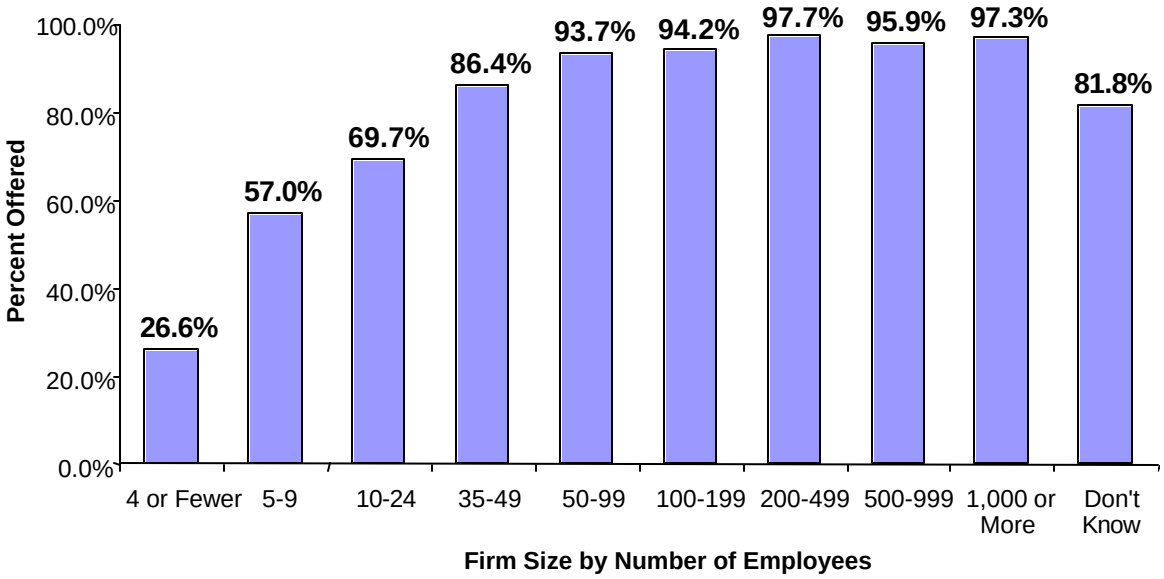
Small firms are least likely to offer coverage. Only about 26.6 percent of workers in firms with fewer than 5 employees are offered coverage through work. By comparison, over 90 percent of employees in firms with over 50 workers were offered health insurance. The proportion of employees offered health insurance increases steadily as firm size increases, and then the percentage increase levels off for firms with over 50 employees at roughly 97 percent. The greatest increase in the percentage of employees offered health insurance occurs between employees who report that they work for firms with fewer than 5 employees and those who report that they work for firms with 5 to 9 employees (***Figure 13***).

**Figure 12**
**Distribution of Vermont Uninsured Workers Aged 18+ by Self-Reported Firm Size, 2000**




Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

**Figure 13**
**Percentage of Workers Offered Health Insurance by Self-Reported Firm Size, Vermont Workers Age 18+, 2000**




Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

## B. Focus Groups and Key Informant Interviews

Sixteen focus group sessions were conducted with employers. Additionally, there were 11 in-depth interviews with employers, resulting in a total of 135 participants. The purpose of the focus groups and interviews with employers was to: (1) identify factors that influence employers' decisions on whether or not to offer health insurance to their employees; and (2) obtain employers' ideas regarding possible ways to expand health insurance coverage in the State of Vermont. Focus group protocols and discussion guides are contained in ***Appendix D***.

Throughout the various employer focus group sessions it became clear that employers who currently offer health insurance and those who do not offer it share very similar views on health insurance and how to expand coverage. Those who offer it reported being very happy to be able to do so, and proud of their health insurance plans. Most of those not offering it reported they would like to be able to offer insurance. All focus group participants, including those not currently offering health insurance, agreed that employers have a social and moral responsibility to offer it. They seemed to believe it is the "right thing to do."

However, nearly all employers in the groups expressed significant frustration with the state of health insurance today and reported having concerns about the future of health insurance. Participants stated that health insurance costs are completely "out of their control," and believe it is impossible to predict, plan or budget for annual health care expenditures.

Few employers currently offering health insurance foresee a time when they will not offer it at all. However, many reported being able to foresee a time when they will need to significantly change the structure of the benefits they offer, either by increasing the employee premium contribution, raising the co-payments or deductibles, or reducing the benefits covered. Small companies were more likely than large ones to report that there might be a time in the future when they could no longer be able to afford to offer health insurance.

Employers who do not offer health insurance identified cost as the primary reason they do not provide coverage. There were several aspects of cost cited by these employers including: premium levels, the unpredictability of costs in the future and the time required to research and administer plans.

### *1. Perceived Value of Health Insurance*

Employers view health insurance as one of the most valuable benefits they can offer, along with paid time off and a retirement savings plan. However, employers were mixed on whether employees value health insurance as a benefit. For example, some employers, particularly those whose workforces consist primarily of young or low-wage employees, agreed that many of their employees would prefer to have paid time off and higher wages rather than health insurance. Several employers indicated that some employees do not value health insurance coverage because they do not fully comprehend what it costs. Participants not currently offering insurance expressed a reluctance to commit to offering health insurance due to rapidly escalating prices.

### 2. Benefits of Offering Insurance

Employers who offer health insurance said they do so to attract and retain employees. Employers who do not offer health insurance recognize that this has a negative impact on their ability to recruit employees. Other reasons cited for offering insurance include: 1) increasing employee compensation with a tax-free benefit; 2) keeping employees healthy and productive; and 3) having access to group health insurance for themselves.

### 3. Costs Associated with Offering Insurance

All employers expressed anxiety over high premiums and significant fluctuations in the cost of health insurance. Many employers stated that costs have increased due to state-mandated benefits (e.g., maternity, mental health and chiropractic) and the effects of community rating. Many believe these mandates have caused insurers to leave the state's insurance market, resulting in a lack of adequate competition and in higher prices. Some employers believe that Vermont does not attract many insurance carriers due to its small size. Others noted that local businesses have a difficult time making enough profit to afford health insurance.

Some participants stated they could only afford policies with a large amount of cost sharing (i.e., premium contributions, deductibles etc.) making employee out-of-pocket costs so high that many employees are not willing to participate. Many insuring employers pass on some or all of the cost of premium increases to employees in the form of increased employee premium contributions, reductions in covered services or higher deductibles and coinsurance amounts.

### 4. Current Offerings

While health plans vary across employers, most employers offer one plan and split the cost of the premiums with their employees. The employees typically pay about 20 percent of the premium.

Employers said that administering benefits for part-time or temporary employees would be difficult due to the variability of the work schedules and thus the uncertainty that the employees will be able to earn enough in wages to pay their portion of the premium. Some employers believe that health insurance is a reward for making a full-time commitment to a company, and therefore do not want to offer the benefit to part-time employees.

### 5. Market Competition

Many employers indicated that increased insurer competition would be the most important catalyst to reducing premiums despite increasing health care utilization and costs. Employers believe that increasing the number of insurers competing for business in Vermont would reduce insurance costs.

Employers agreed that there is sufficient access to information on health plans, but feel that it is confusing and is not presented in a way that permits comparisons across plans.

### *6. Who Should Be Responsible?*

Most employers believe that it should be the responsibility of employers and the government to ensure that all Vermonters have health insurance. Additionally, most believe it should be: 1) Government's role to create a hospitable environment for insurers to do business; 2) Employers' role to offer health insurance to employees; and 3) Employees' role to maintain their health and refrain from abusing the system.

Other government responsibilities include providing insurance to those who are not able to work and assisting employers who cannot afford to offer insurance to their employees. While employers generally had negative feelings about a "government-funded insurance program", they noted that Dr. Dynasaur is an example of a government program that works well.

### *7. Employer Focus Group Participant Recommendations for Expanding Coverage*

Participants expressed that reducing costs is key to expanding insurance coverage and had several suggestions on how to do so:

? Devise employer tax incentives to encourage more employers to offer insurance;

? Encourage more competition in the health insurance market;

? Develop an affordable, basic (not catastrophic) health insurance plan that is free of state mandated benefits;

? Permit insurers to charge less for groups who utilize less care;

? Form a pool of all people in the state to negotiate favorable rates with providers and insurers.

Additionally, participants suggested that the state should:

? Offer catastrophic health insurance to Vermonters who are without insurance, including part-time and temporary employees;

? Provide understandable plan information to facilitate comparison of coverage alternatives;

? Provide rebates to employees who maintain good health and employers whose groups have good health overall;

? Target individual tax incentives such as Medical Savings Accounts and tax deduction for out-of-pocket medical expenses, regardless of the amount.

A small number of employers recommend that the state require health insurance, either by requiring employers to offer it or by requiring individuals to carry it.

## SECTION THREE: HEALTH CARE MARKETPLACE

As part of this project, Lewin conducted a detailed assessment of the Vermont health care system. This included an analysis of trends in health spending by type of service and source of payment. Lewin also performed an assessment of competition in the health care sector and an analysis of cost shifting among hospitals and other providers. In addition, Lewin examined the available data on providers in the state to assess whether there is sufficient provider capacity to meet the increase in demand for health services that would occur among newly insured people under a program of universal insurance coverage.

These analyses were conducted using existing data sources on health services utilization and expenditures in the state. The Division of Health Care Administration provided us with data on health expenditures by type of service and source of payment and detailed hospital utilization and expenditures data. For comparisons across states, Lewin used state level data on health expenditures provided by the Center for Medicare and Medicaid Services (CMS). Lewin also obtained information on hospital spending and services utilization across states from the Medicare hospital cost report data.

In addition to these data analyses, Lewin established two workgroups of industry leaders to advise us on the key issues in the state. These included a workgroup of major insurers serving the state and a separate group of Vermont providers. The results of these analyses are presented in the following sections:

? Health Spending in Vermont;

? Employer Health Spending;

? Cross-State Comparisons;

? Factors Affecting Health Spending Growth;

? Competitive Environment;

? Cost Shifting; and

? Provider Capacity.

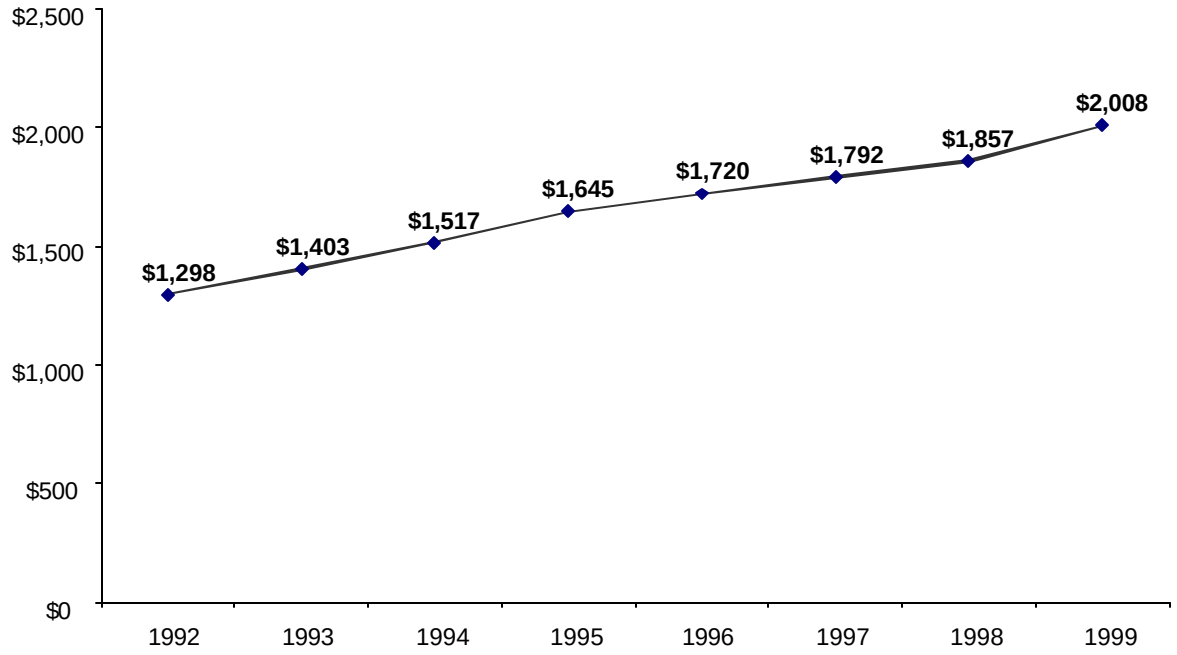
### A. Health Spending in Vermont

This section examines health care spending in Vermont. The analyses presented in this section are based upon health spending data provided by the Vermont Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA). These data provide health spending by and on behalf of Vermont residents regardless of where the services are rendered.

## *1. Statewide Health Spending*

Total health spending for Vermont residents increased from $1.3 billion in 1992 to $2.0 billion in 1999 (***Figure 14***). During this period, per-capita health spending in Vermont grew at an average annual rate of 6.2 percent. Total health care expenditures in Vermont include hospital care, physician services, other professional services, drugs and supplies, home health care, nursing home care, and government health activities. It also includes services rendered by vision providers, DME suppliers, and other miscellaneous providers.

**Figure 14**
**Trends in Total Health Care Spending in Vermont: 1992 - 1999 (thousands)**

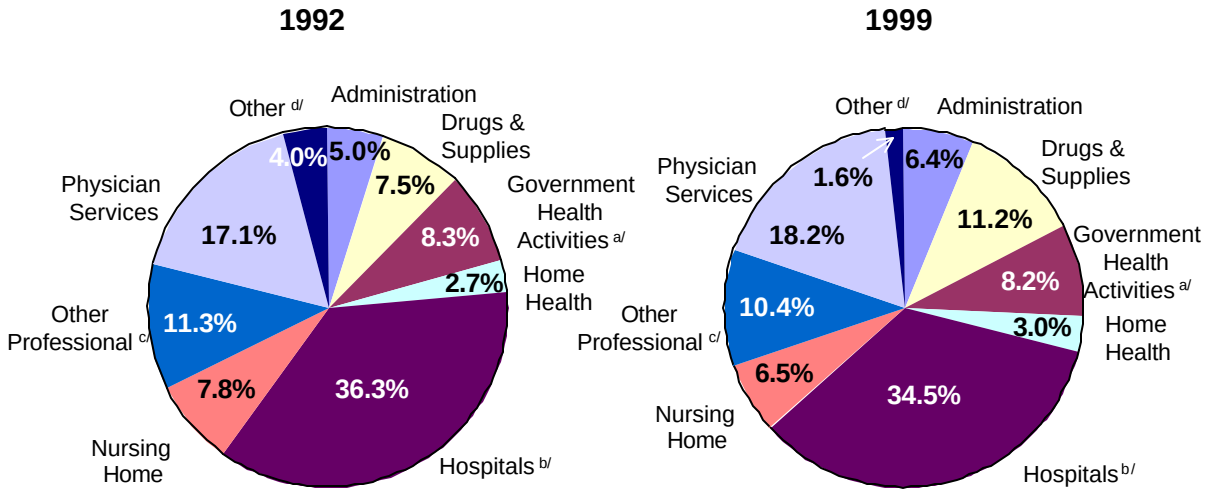



Source: Lewin Group analysis of Vermont Department of Banking, Insurance Securities & Health Care Administration (BISHCA) State Health Expenditures data.

### *a. Health Spending by Type of Service*

***Figure 15*** compares the distribution of health spending by type of service in 1992 and 1999. Hospital and physician services account for over 50 percent of total health care expenditures in Vermont in 1999. The proportion of health care spending attributed to hospital and nursing home services decreased between 1992 and 1999. During this same period, spending for physician service and home health care services increased as a proportion of total Vermont health spending. Similar to national trends, spending for prescription drugs and medical supplies increased as a percent of total health care expenditures.

**Figure 15**
**Vermont Health Spending by Type of Service: 1992 and 1998**



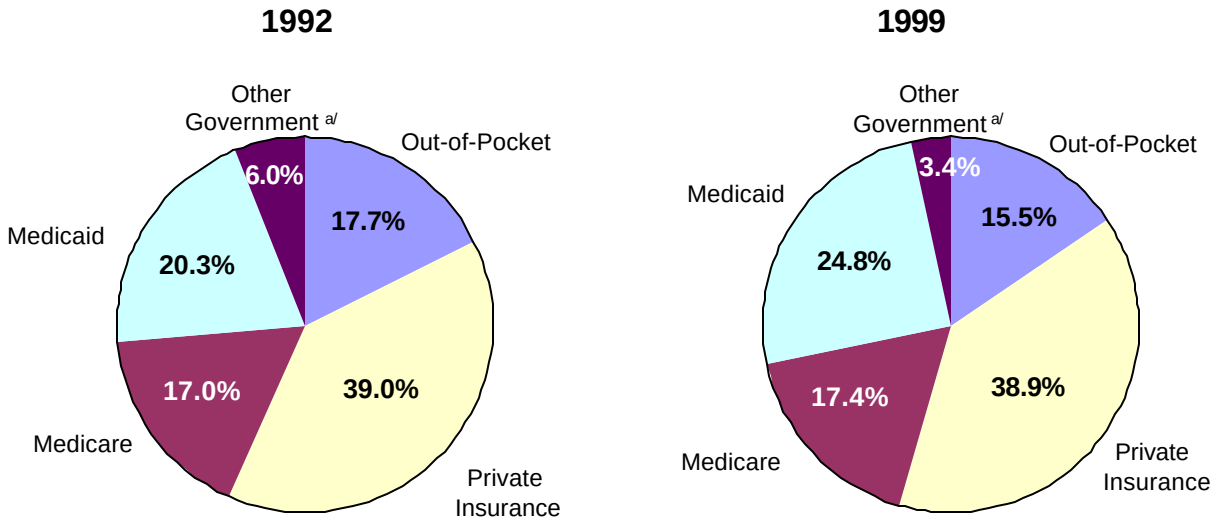

a/ Includes all AHS, Department of Education, Administrative Allocation, and HCA.
b/ Includes community, veterans', and psychiatric (state and private) hospitals.
c/ Includes chiropractor, physical therapy, psychiatric services, podiatrists, dental services, and others.
d/ Includes services rendered by vision providers, DME suppliers and other providers.
Source: Lewin Group analysis of Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) State Health Expenditures data

### *b. Health Spending by Source of Payment*

***Figure 16*** presents estimates of health spending in Vermont by source of payment for 1992 and 1999. Payments for health care are categorized into five payer sources: out-of-pocket payments; payments made on behalf of policy holders by private insurance; and payments through government programs such as Medicare, Medicaid, and other government sources. [1] Medicaid spending increased from 20.3 percent of total health spending in 1992 to 24.8 percent by 1999 reflecting the expansions in eligibility under the program during that time. The proportion of health spending paid for out-of-pocket by consumers declined from 17.7 percent in 1992 to 15.5 percent in 1999. The proportion of total health spending attributed to Medicare and private insurance was largely unchanged over this period.

[1] Out-of-pocket payment include payments made directly by consumers to providers for unmet deductibles; copayments and non-covered services

**Figure 16**
**Vermont Health Spending by Source of Payment: 1992 and 1999**




a/ Includes spending for public health activities by federal or state government that is not covered by Medicare or Medicaid.

Source: Lewin Group analysis of Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) State Health Expenditures data.

### *2. Trends in Health Spending in Vermont by Type of Service*

Total health spending for Vermonters increased by 54.7 percent between 1992 and 1998 (***Figure 17***). Spending for physician services increased by 64.4 percent, while hospital spending grew by only 47.3 percent over this same period. Spending for home health services increased by 71.9 percent during this period while nursing home spending increased by only 29 percent, indicating a shift from nursing homes to home health services in Vermont.

Payments for prescription drugs and medical supplies increased dramatically from $98.0 million in 1992 to $224.8 million in 1999, which is an increase of 129.5 percent over this seven-year period. Also, spending on drugs and supplies has grown more rapidly than any other provider service type during this period. Many factors have contributed to the rapid growth in drug spending, including an increase in drug prices, increased consumer demand for drugs and greater utilization of drugs due to technological advances, and increased direct-to-consumer advertising and marketing of new drugs.

### *3. Trends in Health Spending by Source of Payment*

As shown in ***Figure 17***, Medicaid and Medicare experienced disproportionate growth in spending over the 1992 to 1999 period. While total health spending in Vermont increased by 54.7 percent, Medicaid spending increased by 89 percent over this period. This reflects the growth in eligibility under the program during this period. Medicare spending increased by 60.5 percent between 1992 and 1999.

## Figure 17
## Vermont Health Spending by Type of Service and Source of Payment: 1992 and 1999 (thousands)

| | 1992 | 1999 | Percentage Change |
|---|---|---|---|
| **Type of Service** | | | |
| **Hospital** [a/] | $471,366 | $694,444 | 47.3% |
| **Physician Services** | $221,835 | $364,646 | 64.4% |
| **Other Professional** [b/] | $146,066 | $208,760 | 42.9% |
| **Home Health** | $34,804 | $59,815 | 71.9% |
| **Drugs and Supplies** | $97,967 | $224,842 | 129.5% |
| **Nursing Homes** | $100,911 | $130,151 | 29.0% |
| **Government Health Activities** [c/] | $107,636 | $165,430 | 53.7% |
| **Other** [d/] | $52,390 | $56,654 | 8.1% |
| **Administrative Costs** | $65,136 | $103,604 | 59.1% |
| **Total** | **$1,298,111** | **$2,008,346** | **54.7%** |
| **Source of Payment** | | | |
| **Out-of-Pocket** | $229,361 | $312,283 | 36.2% |
| **Private Insurance** | $511,648 | $780,747 | 52.6% |
| **Medicare** | $217,770 | $349,583 | 60.5% |
| **Medicaid** | $263,137 | $497,426 | 89.0% |
| **Other Government** [e/] | $76,196 | $68,308 | -10.4% |
| **Total** | **$1,298,112** | **$2,008,347** | **54.7%** |

a/ Includes community, veterans', and psychiatric (state and private) hospitals.
b/ Includes chiropractor, physical therapy, psychiatric services, podiatrists, dental services and others.
c/ Includes all AHS, Department of Education, Administrative Allocation, and HCA.
d/ Includes services rendered by vision providers, DME suppliers and other providers.
e/ Includes spending for public health activities by federal or state government that is not covered by Medicare or Medicaid.
Source: Lewin Group analysis of Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) State Health Expenditures data.

By comparison, private insurance spending grew by about 52.6 percent over this period, compared with a growth in total health spending of 54.7 percent. This includes employer-sponsored coverage individually purchased non-group insurance and supplemental coverage for Medicare beneficiaries. Interestingly, out-of-pocked spending increased by only 36.2 percent over this period, which is substantially less than the growth experienced in the public and private sources of insurance. This is thought to be due to the emergence of managed care plans that have little or no copayments for services obtained from network providers. The slower rate of growth in out-of-pocket spending is also partly due to expansions in Medicaid eligibility that covered services for individuals who otherwise would have been uninsured.

Medicare spending in Vermont grew by an average of 5.4 percent per year between 1994 and 1999 (***Figure 18***). The largest rate of growth in the program was skilled nursing facility care. Medicare spending for skilled nursing facilities increased by an average of 21.1 percent per year from 1994 to 1999. In contrast, home health agencies have increased by only 0.1 percent per year

from 1994 to 1999. Medicare spending for "other professional" services also dramatically rose from $1.5 million in 1994 to $3.5 million in 1999, which is an increase of 17.5 percent per year. "Other professional" services include chiropractor, physical therapy, psychiatric services, podiatry, dental services, and other miscellaneous providers.

**Figure 18**
**Medicare Spending in Vermont by Type of Service: 1994 and 1999 (thousands)**

| | 1994 | 1999 | Average Annual Percentage Change |
|---|---|---|---|
| **Medicare** | | | |
| **Hospital** [a/] | $166,427 | $213,838 | 5.1% |
| **Physician Services** | $50,070 | $64,105 | 5.1% |
| **Other Professional** [b/] | $1,543 | $3,457 | 17.5% |
| **Home Health** | $29,303 | $30,752 | 0.1% |
| **Supplies** | $75 | $44 | -10.1% |
| **Skilled Nursing** | $6,594 | $17,145 | 21.1% |
| **Other** [c/] | $9,751 | $14,002 | 7.5% |
| **Administrative Costs** | $5,275 | $6,239 | 3.4% |
| **Total** | **$269,038** | **$349,582** | **5.4%** |

a/ Includes community, veterans', and psychiatric (state and private) hospitals.
b/ Includes chiropractor, physical therapy, psychiatric services, podiatrists, dental services and others.
c/ Includes services rendered by vision providers, DME suppliers and other providers.
Source: Lewin Group analysis of Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) State Health Expenditures data.

Medicaid spending in Vermont increased at an average annual rate of 10.4 percent between 1994 and 1999 (***Figure 19***). As discussed below, the growth in Medicaid enrollment was the primary reason for the large increase in Medicaid spending during this period. Prescription drugs and supplies accounted for the largest percentage increase in Medicaid spending (20.1 percent per year) between 1994 and 1999. Home health services had the second largest increase in Medicaid spending during these years (16.1 percent per year), while nursing home care had the lowest increase in Medicaid spending during this time period (1.5 percent per year). Expenditures for physician services increased by an average of 15.4 percent per year, while hospital service costs increased by 6.2 percent per year.

**Figure 19**
**Medicaid Spending in Vermont by Type of Service:**
**1994 and 1999 (thousands)**

| | 1994 | 1999 | Average Annual Percentage Change |
|---|---|---|---|
| **Medicaid** | | | |
| **Hospital** [a/] | $64,456 | $86,925 | 6.2% |
| **Physician Services** | $19,560 | $40,023 | 15.4% |
| **Other Professional** [b/] | $7,080 | $13,105 | 13.1% |
| **Home Health** | $8,035 | $16,953 | 16.1% |
| **Drugs and Supplies** | $25,227 | $63,117 | 20.1% |
| **Nursing Homes** | $71,129 | $76,530 | 1.5% |
| **Government Health Activities** [c/] | $76,673 | $147,617 | 14.0% |
| **Other** [d/] | $9,122 | $12,972 | 7.3% |
| **Administrative Costs** | $22,568 | $40,184 | 12.2% |
| **Total** | **$303,850** | **$497,426** | **10.4%** |

a/ Includes community, veterans', and psychiatric (state and private) hospitals.
b/ Includes chiropractor, physical therapy, psychiatric services, podiatrists, dental services and others.
c/ Includes all AHS, Department of Education, Administrative Allocation, and HCA.
d/ Includes services rendered by vision providers, DME suppliers and other providers.
Source: Lewin Group analysis of Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) State Health Expenditures data.

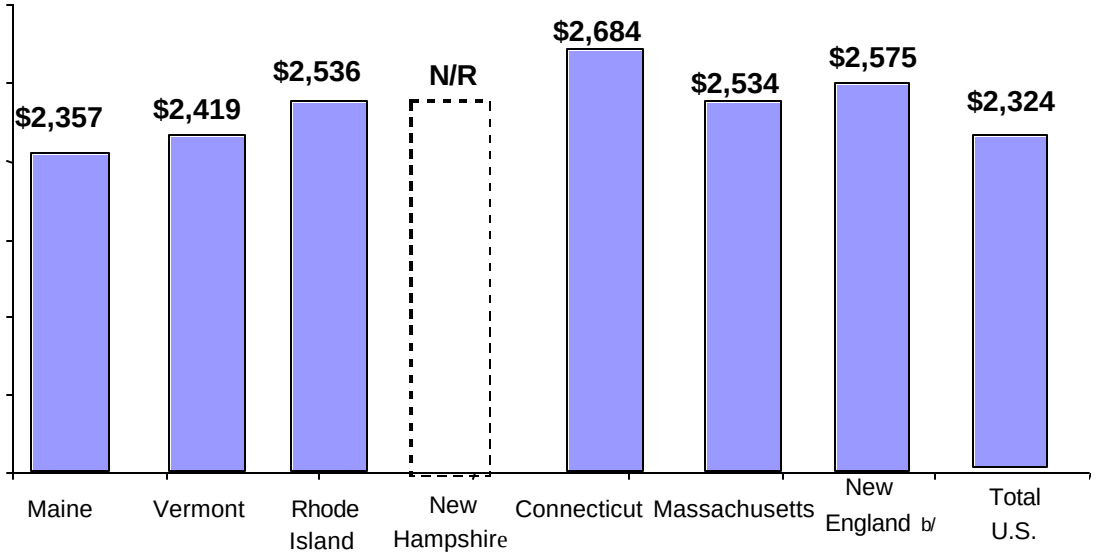
## B. Employer Health Spending in Vermont

In this section Lewin examined spending for employer-based health insurance in Vermont compared to the New England region and the nation. Overall, Lewin found that spending for employer-based health insurance in Vermont was very similar to the national average and somewhat lower than average employer-based health insurance spending in other New England states.

The analysis is based upon the 1999 Medical Expenditures Panel Survey (MEPS) data for employers compiled by The Agency for Healthcare Research and Quality (AHRQ). These data provide a sample of about 800 employers in each state. At this time, data on average premiums per worker are available for 40 states including Vermont. These data permitted Lewin to compare health spending per worker in employer-sponsored plans across the nation.

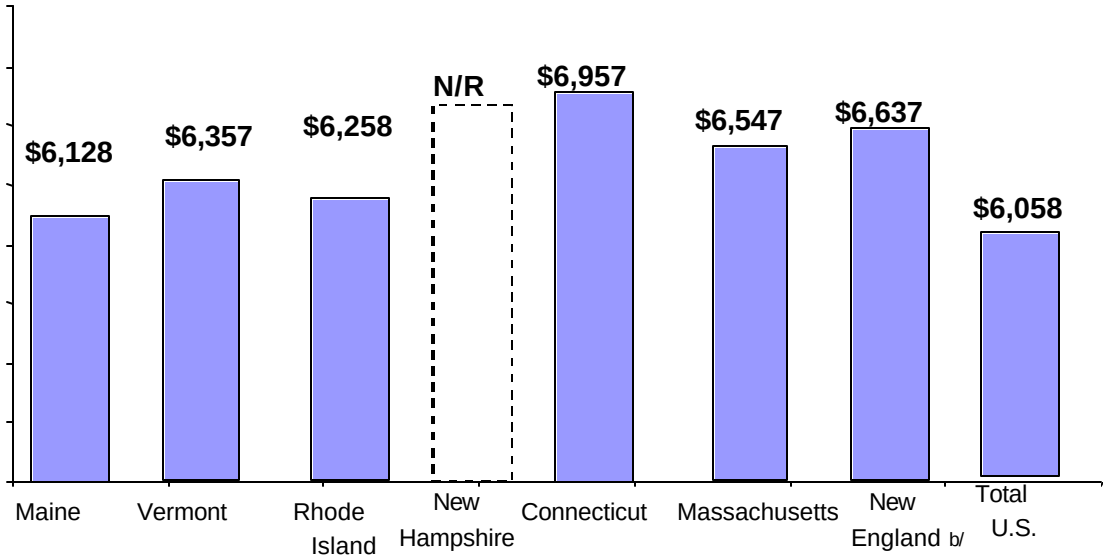
These data provide estimates of average employer-based health insurance premiums for workers in Vermont for single and family coverage (***Figures 20*** and ***21***). The average cost of employer coverage in Vermont (employee and employer share) in 1999 was $2,419 for single coverage and $6,357 for family coverage. This is above the national average of $2,324 for single coverage and $6,058 for family coverage. However, Vermont spending for employer policies is also less than the overall average for the New England states, of $2,575 for single coverage and $6,637 for family coverage.

**Figure 20**
**Average Employer-Based Health Insurance Premium Costs Per Worker with Individual Coverage in 1998 [a/]**




N/R- Not Reported
a/ Estimated premium costs include benefits payments and administrative costs.
b/ Excludes New Hampshire
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

**Figure 21**
**Average Employer-Based Health Insurance Premium Costs Per Worker with Family Coverage in 1998 [a/]**




N/R- Not Reported
a/ Estimated premium costs include benefits payments and administrative costs.
b/ Excludes New Hampshire
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

These data have certain limitations. For example, they do not take into account the differences in benefits packages (i.e., covered services, deductible levels, and co-payment amounts) offered by employers across the states. Thus, it is not known whether the differences in employer spending levels across states are due to the level of benefits offered by the employers or other factors such as utilization. It also does not standardize the differences in insurer administrative costs and profit levels across states. Another limitation is that they exclude spending for government workers.

The findings from this analysis are consistent with information received during interviews with benefits managers from multi-state employers with offices in Burlington, Vermont. One of these employers was able to provide cost data for workers in different states. The employer self-insures its employees and uses a third party administrator to manage claims. The benefits manager stated that per-capita health spending for covered employees and their dependents was 'right in the middle' compared to other sites in Texas, California, Seattle and nine other areas nationally.

## C. Cross-State Comparisons of Health Spending

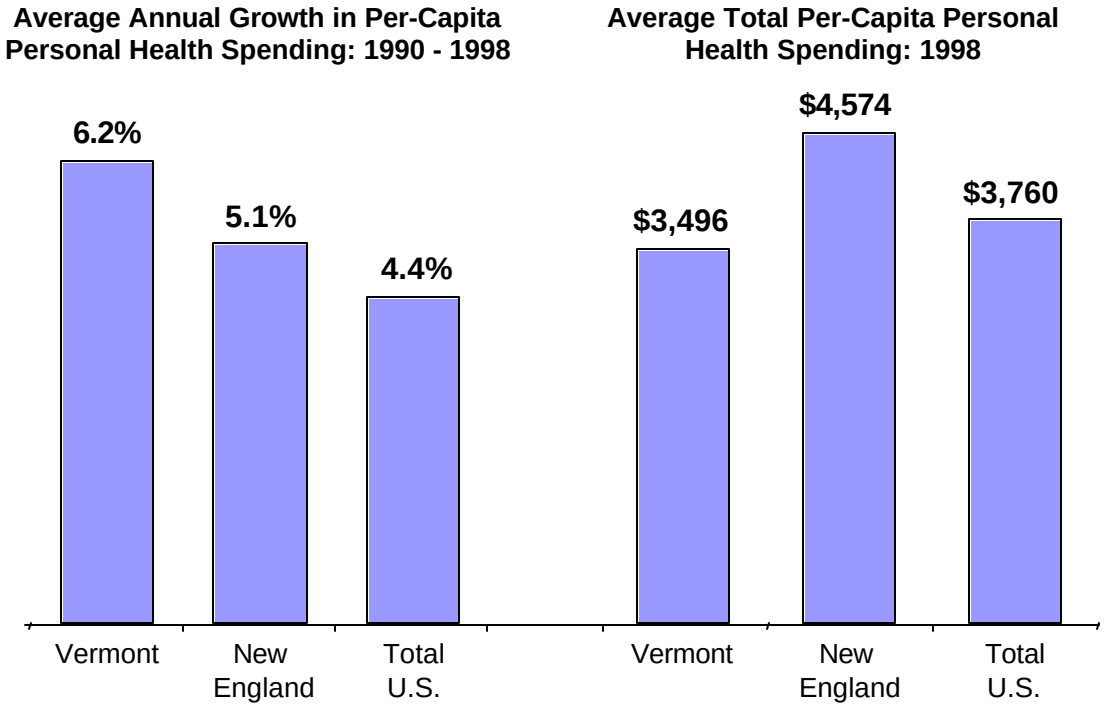
This section presents a comparison of health spending trends in Vermont with regional and national trends. Lewin relied on CMS data, which are collected in a consistent manner across states suitable for comparisons.

### *1. Trends in Per-Capita Health Spending*

Per-capita health spending in Vermont grew faster than the regional and national average over the 1992 to 1998 period. However, per-capita health expenditures in Vermont were still below per capita spending for New England and the U.S in 1998 (***Figures 22*** and ***23***). Between 1992 and 1998, the average annual growth in per-capita spending was 6.2 percent in Vermont compared to 5.1 percent in New England and 4.4 percent in the U.S. Per-capita health spending in Vermont in 1998 was $3,496 compared to $4,574 in New England and $3,760 in the U.S.

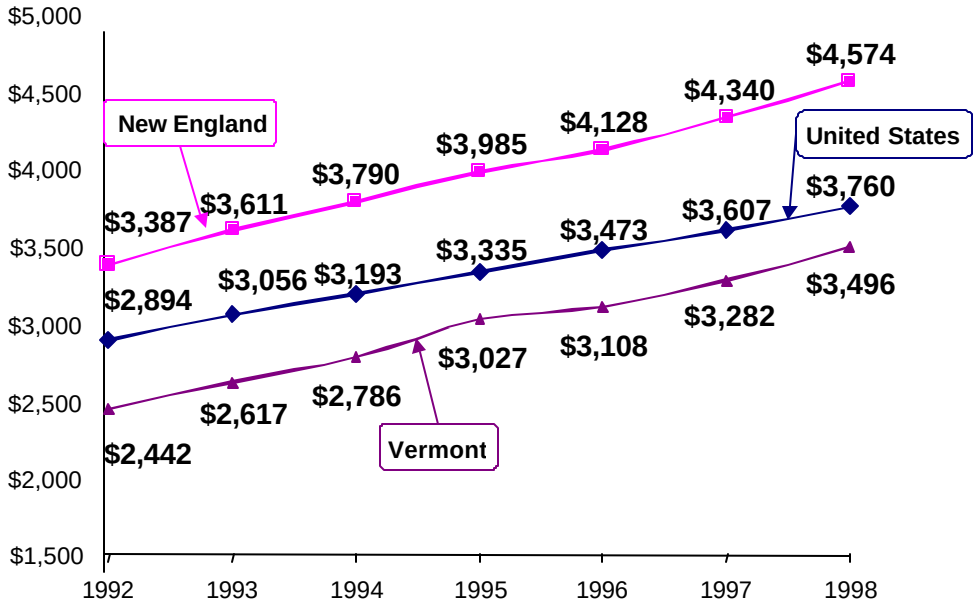
Personal health spending in Vermont increased from 11.1 percent of State Gross Domestic Product (GDP) in 1992 to 12.7 in 1998 (***Figure 24***). Health spending as a percent of State GDP in the New England region declined from 12.5 percent to 12.2 percent during the same period. Similarly, health spending as a percent of GDP in the U.S. declined as well during this period. This reflects both a higher rate of growth in health spending in the state and the fact that State GDP in Vermont has grown more slowly than in other states.

**Figure 22**
**Per-Capita Personal Health Spending in Selected Geographical Regions: 1992 - 1998**



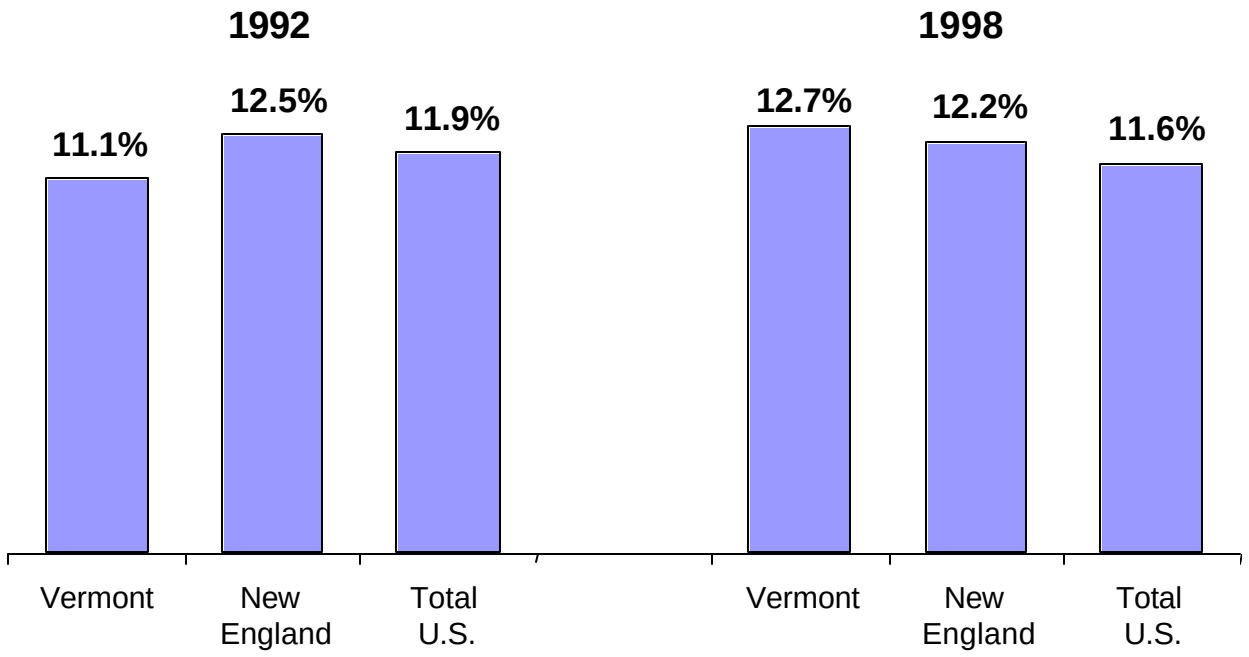

Source: Lewin Group analysis of the Centers for Medicare and Medicaid Services (CMS) State Health Expenditures data.

**Figure 23**
**Total Per-Capita Personal Health Spending: 1992 - 1998**




Source: Lewin Group analysis of the Centers for Medicare and Medicaid Services (CMS) State Health Expenditures data.

**Figure 24**
**Personal Health Care Spending as a Percentage of Gross Domestic Product (GDP) 1992 and 1998**



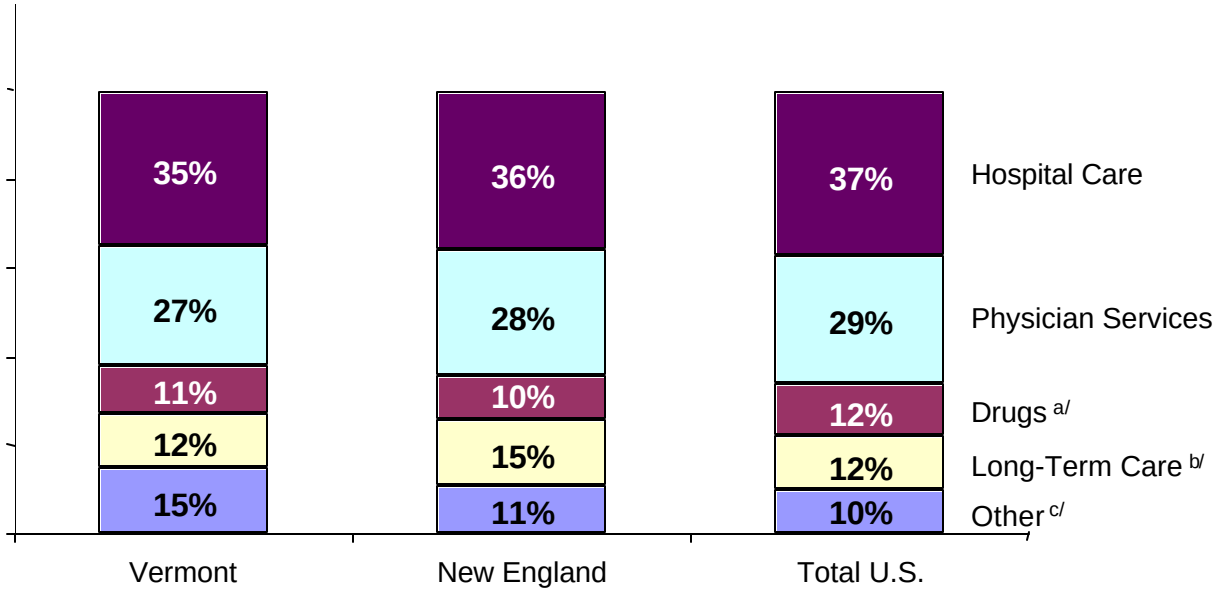

Source: Lewin Group analysis of the Centers for Medicare and Medicaid Services (CMS) State Health Expenditures data and Gross State Product data from the Bureau of Economic Analysis

### *2. Trends in Health Spending by Type of Service*

The distribution of health spending by type of service in Vermont was generally similar to the health spending distribution in the New England area and the U.S. (***Figure 25***), Hospitals were the largest provider of health services in Vermont (35 percent), New England (36 percent), and the U.S. (37 percent). Physicians were the second largest provider of services. Both physician and hospital services represented over 50 percent of total health care expenditures in Vermont, New England, and the U.S.

However, health spending growth in Vermont varied considerably from the growth in spending in the New England region and nationally across the various types of services between 1992 and 1998 (***Figure 26***). Spending for hospital, physician, and other professional services in Vermont increased at a much faster rate than in New England and nationally. Spending for prescription drugs and long term care services in Vermont increased at less than the national average. The above-average growth rates for hospital, physician, and other professional services are the primary reason why total personal health care expenses in Vermont have increased faster then the national and regional average.

## Figure 25
## Distribution of Health Spending as a Percentage of Personal Health Care Expenditures: 1998




a/ "Drugs" includes other medical non-durables.
b/ "Long-term care" includes home health care and nursing home care.
c/ "Other" includes dental services, vision products, and other medical durables, and other personal health care.
Source: Lewin Group analysis of the Centers for Medicare and Medicaid Services (CMS) State Health Expenditures data (excludes administrative, research, construction and public health activities).

## Figure 26
## Average Annual Change in Per-Capita Personal Health Spending by Type of Service 1992-1998

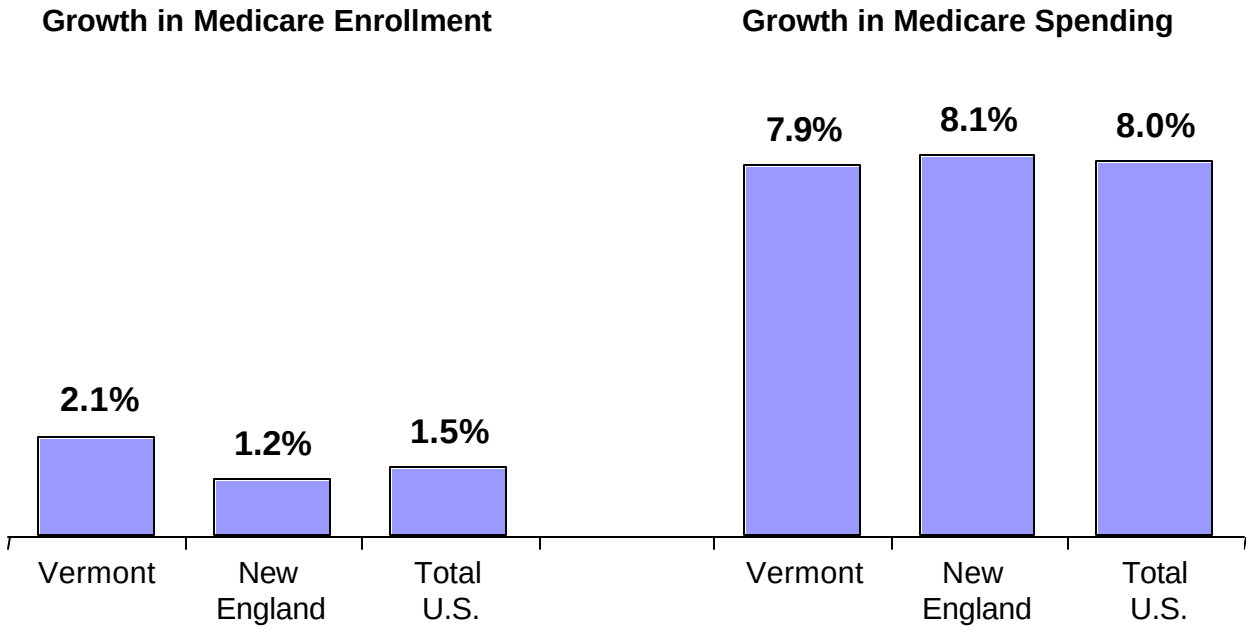
| Type of Service | Vermont | New England | Total U.S. |
|---|---|---|---|
| **Total Personal Health Care** | 6.2% | 5.1% | 4.4% |
| **Hospital Care** | 4.4% | 3.1% | 2.9% |
| **Physician & Other Professional Services** | 7.0% | 5.8% | 4.2% |
| **Dental Services** | 6.9% | 5.5% | 5.4% |
| **Home Health Care** | 5.7% | 6.5% | 8.3% |
| **Prescription Drugs** | 10.7% | 11.6% | 10.6% |
| **Vision Products & Other Medical Durables** | 3.3% | 3.9% | 3.5% |
| **Nursing Home Care** | 3.1% | 4.2% | 4.9% |
| **Other Personal Health Care** | 14.9% | 14.2% | 12.0% |

Source: Lewin Group analysis of the Centers for Medicare and Medicaid Services (CMS) State Health Expenditures data.

### *3. Trends in Spending for Medicare and Medicaid*

During the 1992 to 1998 period, the growth in Medicare spending in Vermont was similar to the growth in the New England region and the nation (***Figure 27***). However, Medicare enrollment in Vermont increased at an annual rate of 2.1 percent compared to the 1.2 percent for New England region and 1.5 percent nationally. Between 1992 and 1998, Medicare enrollment in Vermont increased by 13.0 percent compared to 7.2 percent in New England and 9.0 percent nationally.

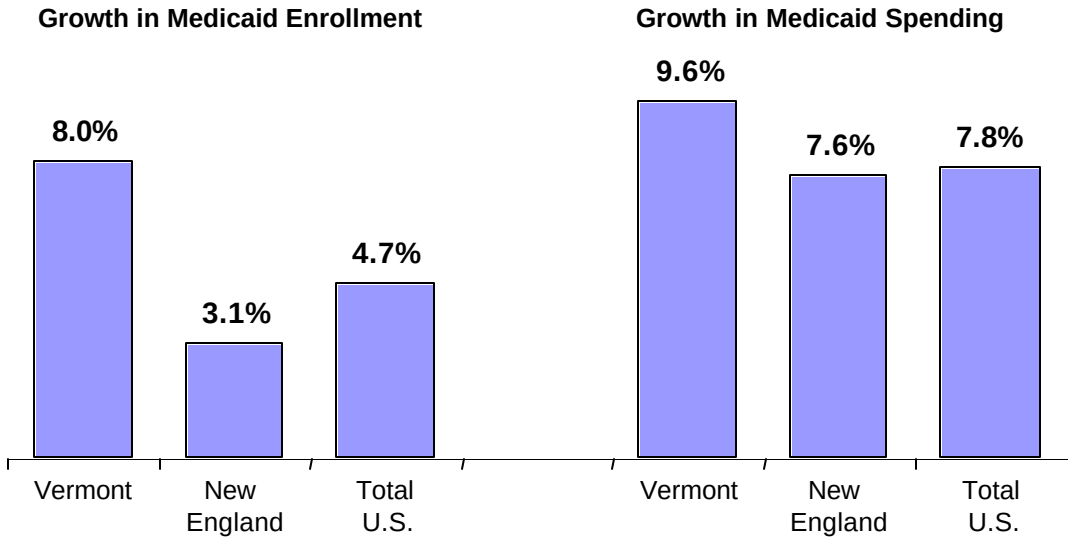
**Figure 27**
**Average Annual Change in Medicare Enrollment and Spending: 1992 - 1998**




Source: Lewin Group analysis of the Centers for Medicare and Medicaid Services (CMS) State Health Expenditure data.

As discussed above, during the 1992 to 1998 period, spending for Medicaid increased significantly more for Vermont than for the New England and the U.S. (***Figure 28***). Spending in Vermont increased by an average of 9.6 percent per year compared with an average of 7.6 percent in the New England states and 7.8 percent nationally. The increase in Medicaid spending in Vermont is driven primarily by high enrollment growth during that period. Medicaid enrollment in Vermont grew at nearly twice the rate that it grew in the New England area and nationally.

**Figure 28**
**Average Annual Change in Medicaid Enrollment and Spending: 1992 - 1998**




Source: Lewin Group analysis of the Centers for Medicare and Medicaid Services (CMS) State Health Expenditure data.

## D. Factors Affecting Cost Growth

As discussed above, personal health care spending in Vermont increased from $1.4 billion in 1992 to $2.1 billion in 1998. This represents an average annual increase in per-capita health spending of 6.2 percent during this period, which is above the rate of growth in health spending nationally (4.4 percent) and in the New England region (5.1 percent). These increases in spending reflect a range of trends that have affected health care costs such as the aging of the population, utilization increases, changes in technology, wage growth in the health sector, and inflation for medical equipment and supplies.

The purpose of this section is to examine the factors contributing to health care cost growth. Some of the information on the sources of cost growth is available from the Office of the Actuary of CMS (formerly HCFA). Data on population growth and health services utilization is available from other public and private sources. The components of health spending growth are described below. Data on trends in these factors for Vermont are presented where available.

### *1. Historical Components of Health Care Cost Growth*

Research conducted by the CMS Office of the Actuary identifies the factors that have contributed to the historic increases in health spending. These include:

? **Population Growth:** Includes births and immigration.

? **Changes in the Demographic Composition of the Population:** Reflects primarily the aging of the population.

? **General Inflation:** As measured by the Consumer Price Index (CPI) or the Gross National Product (GNP) deflator preferred by some economists.

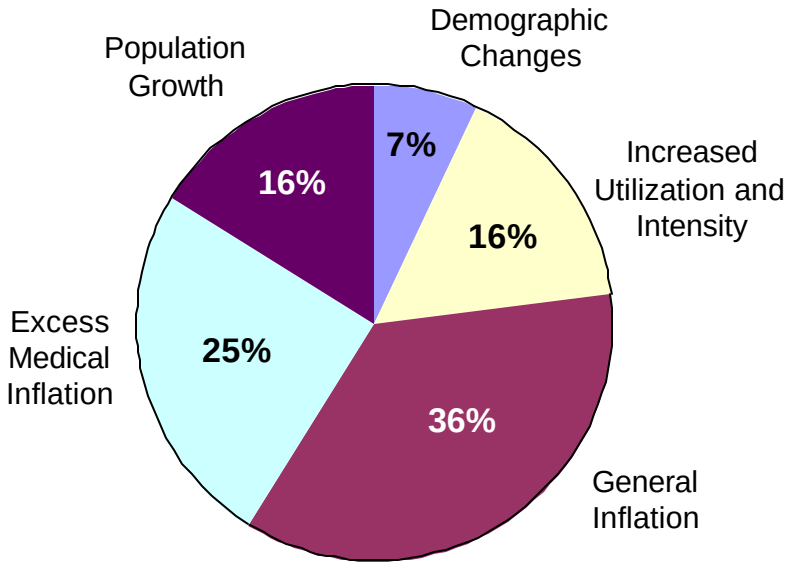
? **Excess Medical Inflation:** Includes spending increases attributed to changes in provider prices for services.

? **Increased Utilization:** Includes changes in utilization of health services.

? **Service Intensity:** This is a proxy measure for the growth in medical technology (e.g., new drug therapies, new surgical procedures, etc.).

About 59 percent of health spending growth is attributed to factors that are essentially beyond the control of the health care system itself. For example, 36 percent of cost growth has been attributed to general price inflation as measured by the CPI (***Figure 29***). Another 16 percent is attributed to population growth due to births and immigration. An additional 7 percent is attributed to underlying changes in the demographic characteristics of the population. These include the aging of the population and reflect other factors such as changes in racial/ethnic mix. These sources of growth will continue to increase costs indefinitely regardless of the course of medical technology.

**Figure 29**
**Composition of Personal Health Spending Growth 1992-1998**




Source: Lewin Group analysis of the Centers for Medicare and Medicaid Services, National Health Expenditures data.

The remaining 41 percent of health care cost growth is attributed to factors related to the practice of medicine itself. About 25 percent of cost growth was attributed to increases in the prices charged for medical goods and services by providers in excess of general price inflation. Another 16 percent of cost growth is attributed to increases in health services utilization and an increase

in service intensity.[2] Service intensity is a catch-all term for shifts to more advanced therapies, which is considered to be a proxy measure of the proliferation of new technology.

### *2. Impact of Population-Based Changes on Health Spending Growth*

Population-based changes in health spending include two factors:

? **Total Population Growth,** which is the annual percentage growth in state population; and

? **Changes in Demographic Mix of the Population,** including the aging of the population and changes in racial/ethnic mix (i.e., increase in average age).

Population growth was less of a factor in spending growth for New England than it was nationally. Over the 1992 through 1998 period, population growth in Vermont accounted for an average annual spending increase of 0.6 percent in Vermont compared with an average of 0.3 percent in the New England states and 1.0 percent nationally (***Figure 30***).

**Figure 30**
**Impact of Population and Demographic Changes on Health Spending**
**1992 to 1998**

| | Average Annual Change in Population from 1992-1998 | Average Annual Impact of Demographic Changes 1992-1998 | Average Annual Impact of Population-Based Changes 1992-1998 |
|---|---|---|---|
| **Vermont** | 0.6% | 0.8% | 1.4% |
| **New England** | 0.3% | 0.5% | 0.7% |
| **U.S.** | 1.0% | 0.4% | 1.4% |

Source: Lewin Group analysis of the Bureau of the Census data and data from the Centers for Medicare and Medicaid Services (CMS) State Health Expenditures.

The aging of the population has played a more significant role in health spending growth in Vermont than has been seen nationally or in the New England region. The changes in the demographic composition of the population in Vermont accounted for an additional 0.8 percent annual increase in health spending compared to only 0.4 percent nationally. This is because Vermont includes a proportionally higher share of the baby-boom population when compared to other states (***Figure 31***). Thus, Vermont is affected proportionally more as the state's baby-boom population ages into higher health care cost age groups.

[2] Critics of these analyses have argued that the method used to measure excess medical inflation probably reflects some of the increase in service intensity due to measurement problems.

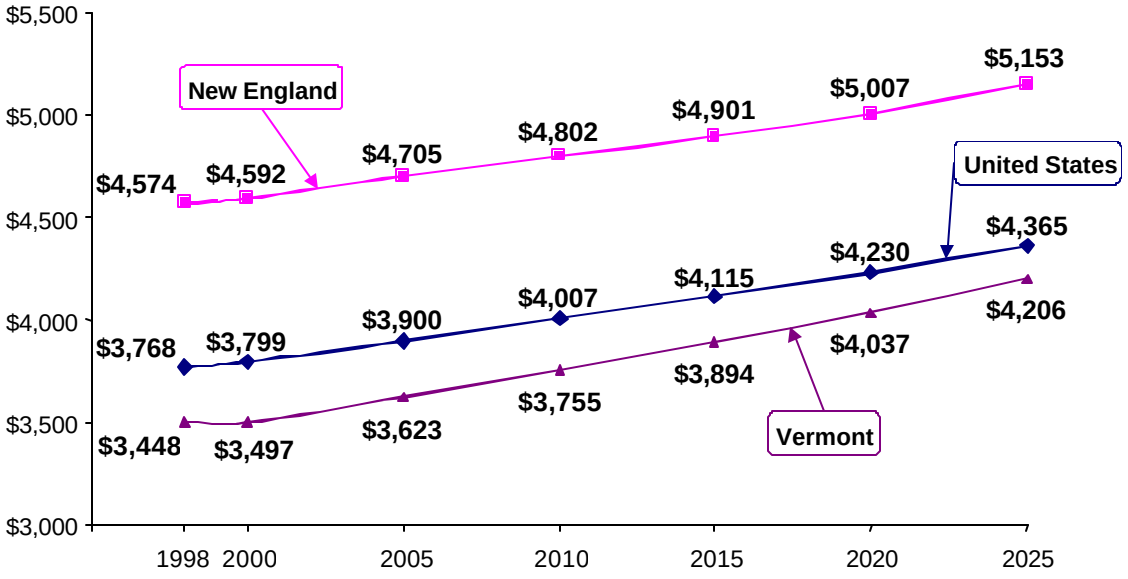
**Figure 31**
**Age Distribution for Vermont, New England and the United States, 1999**

| State/Region | Age 0 - 3 | Age 4 - 19 | Age 20 - 34 | Age 35 - 49 | Age 50 - 64 | Age 65 or Older |
|---|---|---|---|---|---|---|
| Vermont | 4% | 22% | 20% | 26% | 15% | 12% |
| New England | 5% | 22% | 20% | 24% | 15% | 14% |
| U.S. | 6% | 23% | 21% | 24% | 15% | 13% |

Source: United States Census Bureau.

Changes in the demographic composition of the population will have a significant impact on the growth in health spending in future years as the 'baby boomers' age into Medicare. ***Figure 32*** shows per-capita health spending projections for Vermont, New England, and the U.S., holding all factors constant except for the demographic mix of the population. The aging of the population will continue to have a greater impact on health spending growth in Vermont as compared to the New England region and the United States through 2025.

**Figure 32**
**Change in Per-Capita Health Spending Due to Demographic Changes [a/]: 1998 – 2005**




a/ Per capita health spending projections control for changes in the age and sex composition of the population while holding expenditures constant at 1998 levels.

Source: Lewin Group analysis of the Centers for Medicare and Medicaid Services (CMS) State Health Expenditures data.

Lewin estimates that demographic changes in Vermont alone will increase per-capita expenditures in Vermont by 22 percent by 2025 even before accounting for inflation and medical technology growth. This compares to a projected increase of 15.8 percent for the United States and 12.7 percent for the New England region over this period. This greater than average cost

growth will be particularly burdensome in Vermont because the state's GDP has historically grown more slowly than the GDP of other states.

### *3. Economy-wide and Excess Medical Inflation*

During the 1992 through 1998 period, general inflation averaged about 1.9 percent annually. This accounted for about one-third of the total increase in health spending over this period. Excess medical inflation is the increase in prices for a market basket of medical goods and services that is over and above economy-wide inflation. During the 1992 through 1998 period, excess medical inflation averaged about 1.1 percent and accounted for 25 percent of the increase in health spending.[3]

Estimates of excess medical inflation are not available separately for Vermont. However, we do know that there is less use of managed care in Vermont than elsewhere. This is important because areas with wide use of selective contracting and managed care have been shown to have lower rates of growth in health spending (discussed above).

### *4. Increase in Utilization and Service Intensity*

As part of the hospital budget review process, BISHCA collects extensive information on trends in hospital capacity and utilization. Since 1998, hospital inpatient capacity in Vermont has remained stable at about 1,120 beds (***Figure 33***). Inpatient admissions and days have increased slightly since 1998, which reflect a nationwide trend towards a small increase in inpatient admissions. Length of stay has generally declined slightly in Vermont from 4.9 days in 1994 to 4.7 days in 2001.

A comparison of hospital inpatient utilization in Vermont to the other regions shows that utilization rates for acute care inpatient services (admissions and days) declined faster for Vermont hospitals than nationally and in New England from 1995 to 1999 (***Figure 34***)**.** However during that same period, hospital outpatient visits increased substantially more in Vermont than for New England hospitals and the nation. The increase in hospital outpatient utilization may be associated with hospitals purchasing physician groups in the state.

The available data indicates that Vermont's use of hospital services overall is actually less than the national average. ***Figure 35*** presents estimates of the average number of "adjusted hospital admissions" per 1,000 people for selected states and regions. Adjusted hospital admissions are a composite measure of hospital utilization that reflects the use of both inpatient and outpatient hospital care. It is computed as the sum of inpatient admissions and a count of outpatient visits converted to "inpatient equivalent" units of hospital utilization. This measure is useful in comparing hospital utilization in areas where practice patterns may differ in terms of the emphasis placed on inpatient and outpatient care.

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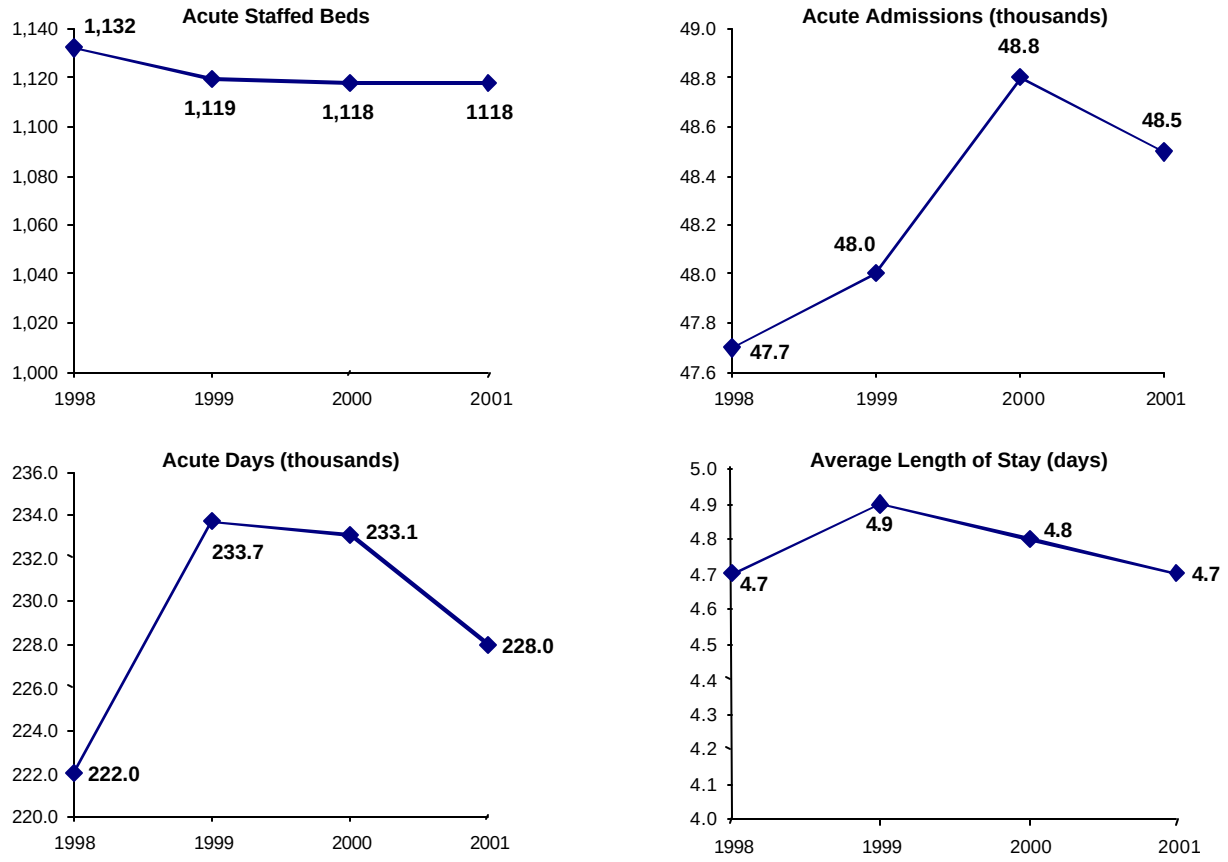
[3] One criticism of the CMS estimates is that due to data limitations, excess medical inflation may reflect the shift to more intensive therapies rather than a change in prices for a given set of services, which is what excess medical inflation is intended to measure.

**Figure 33**
**Inpatient Utilization Trends in Vermont: 1995 - 2001**




Source: Lewin Group analysis of Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) State Health Expenditures data.

These data show that average adjusted admissions in Vermont were 169, compared to a national average of 190 and an average of 201 for New England. Vermont ranked 14th highest among the states in terms of adjusted admissions per 1,000 people. When we adjusted these data to reflect differences in the age and sex composition of state populations, Vermont is ranked only 10th highest among the states. These data indicate that while outpatient utilization in Vermont is growing faster than the rest of the nation, the actual level of utilization in the state is less than that in most other states.

## *5. Coverage Expansions in Vermont*

Vermont has implemented expansions in its Medicaid/VHAP/Dr. Dynasaur programs that have reduced the number of the uninsured during the 1990s. The increase in the number of people with health insurance is likely to have resulted in increases in utilization, because insured people utilize more health services than uninsured people (***Figure 36***). Thus, increases in health insurance coverage in the state probably had a direct effect on health spending.

## Figure 34
## Acute Care Hospital Utilization Statistics 1995-1999

| Utilization Statistic | Vermont | New England | Total U.S. |
|---|---|---|---|
| **1999** | | | |
| Acute Hospital Admissions per 1,000 People | 85 | 109 | 117 |
| Acute Hospital Inpatient Days per 1,000 People | 456 | 584 | 608 |
| Acute Hospital Adjusted Admissions per 1,000 People | 156 | 188 | 177 |
| Emergency Room Visits per 1,000 People | 371 | 429 | 365 |
| Other Hospital Outpatient Visits per 1,000 People | 2,010 | 1,871 | 1,452 |
| **1995** | | | |
| Acute Hospital Admissions per 1,000 People | 94 | 113 | 116 |
| Acute Hospital Inpatient Days per 1,000 People | 534 | 668 | 666 |
| Acute Hospital Adjusted Admissions per 1,000 People | 164 | 174 | 166 |
| Emergency Room Visits per 1,000 People | 365 | 434 | 361 |
| Other Hospital Outpatient Visits per 1,000 People | 1,427 | 1,547 | 1,216 |
| **Average Annual Percent Change 1995-1999** | | | |
| Acute Hospital Admissions per 1,000 People | -2.5% | -0.9% | 0.1% |
| Acute Hospital Inpatient Days per 1,000 People | -3.9% | -3.3% | -2.2% |
| Acute Hospital Adjusted Admissions per 1,000 People | -1.2% | 1.9% | 1.6% |
| Emergency Room Visits per 1,000 People | 0.4% | -0.3% | 0.3% |
| Other Hospital Outpatient Visits per 1,000 People | 8.9% | 4.9% | 4.5% |

Source: Lewin Group analysis of the AHA Hospital Statistics 2001 Health Forum LLC.

## Figure 35
## Adjusted Hospital Admissions per 1,000 People by State

| State/Region | Adjusted Admissions Per 1,000 [a/] | | |
|---|---|---|---|
| | Average | State Rank | |
| | | Unadjusted | Adjusted |
| Vermont | 169 | 14 | 10 |
| New England | 201 | NA | NA |
| Maine | 207 | 33 | 34 |
| New Hampshire | 177 | 17 | 28 |
| Massachusetts | 226 | 41 | 30 |
| Connecticut | 165 | 12 | 9 |
| Rhode Island | 212 | 38 | 43 |
| U.S. Average | 190 | NA | NA |

a/ Cost per Adjusted Admission is defined as total hospital operating expenses divided by number of adjusted admission. Adjusted admissions is the sum of inpatient admission and equivalent admissions attributed to outpatient services (derived by multiplying admissions by the ratio of outpatient revenue to inpatient revenue).

Source: Lewin Group analysis of the Medicare Hospital Cost Report Data for 1998 and Health Forum LLC, AHA Hospital Statistics 2001.

**Figure 36**
**Health Services Utilization for People Under Age 65 by Insured Status [a/]**
**in Vermont**

| | Uninsured | Insured | Total |
|---|---|---|---|
| **Physician Visits per 1,000** | 1,705 | 3,650 | 3,549 |
| **Dental Visits per 1,000** | 565 | 1,222 | 1,188 |
| **Hospital Stays per 1,000** | 68 | 79 | 78 |
| **Outpatient Visits per 1,000** | 305 | 484 | 475 |
| **Emergency Room Visits per 1,000** | 204 | 188 | 189 |

a/ Utilization rates per 1,000 people
Source: Lewin Group analysis using the Vermont version of the Health Benefit Simulation Model (HBSM).

Based on BISCHA data, the proportion of people in Vermont with health insurance increased from 89.2 percent in 1993 to 93.9 percent in 1997. Coverage then declined slightly in 2000 to 91.6 percent. (The increase in the uninsured population between 1997 and 2000 was not statistically significant.) This increase was due primarily to increases in enrollment in the State's Medicaid program. This compares to national trends indicating that the percent of people with health insurance declined by one percentage point during this same period.

### *6. Reasons for Higher Cost Growth in Vermont*

As discussed above, between 1992 and 1998, per-capita health spending grew by an average of 6.2 percent per year compared with an average of 4.4 percent nationwide. Although there are substantial data limitations the available information provides some insights into why spending in Vermont has grown so rapidly. These include the following:

? **Growth in Outpatient Hospital Utilization:** Per-capita hospital spending grew by 4.4 percent in Vermont over this period compared with a nationwide average of 2.9 percent (see ***Figure 26*** above). Most of the growth in Vermont was concentrated in outpatient hospital services (8.9 percent per year compared with 4.5 percent nationally, ***Figure 34*** above). In fact, inpatient hospital utilization in Vermont grew at a slower rate than it did nationwide.

? **Physician Spending:** Per-capita spending on physician services increased at an annual rate of 7.0 percent in Vermont compared to 4.2 percent nationally over the 1992 through 1998 period (***Figure 26***, above). Unfortunately, the data do not provide the information needed to determine whether this is due to a higher rate of increase in utilization or physician charges.

? **Reduction in Uninsured:** The available data indicate that the percentage of people without coverage declined from 10.8 percent in 1993 to 8.4 percent by 2000. Much of this reduction in the uninsured is attributed to expansions in Medicaid that were implemented in Vermont over the 1990s. The available research indicates that this increase in coverage would have been associated with increased utilization of health services.

? **Demographics:** Vermont includes a proportionally large share of the baby-boom population than in most other states. Consequently, the impact that the aging of this population has had in Vermont is proportionally greater than the national average.

## E. Assessment of Competitive Environment in Vermont

An important issue in Vermont is the perceived lack of competition among insurers. The number of insurers serving the state has declined in recent years, and is thought by some to be largely due to the guaranteed issue and community rating legislation adopted in 1992.[4] In addition, there appears to be little competition among providers in the state, which is likely to be contributing to health care cost growth. Competition within the health care system can exist on two levels:

? First, in large markets with many providers, there is usually a great deal of price competition among hospitals and provider groups. For example, hospitals often offer a substantial price discount to managed care plans in exchange for treating a greater volume of patients from those plans. This environment is most likely to exist in areas with several alternative hospitals or physician groups, and in areas where there are large numbers of people enrolled in managed care plans where the plan has control over the providers that patients use.

? Second, competition also can occur at the health-plan level. For example, in large markets with many health plans, carriers compete for customers on the basis of price and other factors such as access to providers and the perceived quality of care provided. In this environment, plans are motivated to reduce premiums wherever possible to attract greater market share. This competition can result in improved efficiency in administering benefits with substantial consumer benefit.

The purpose of this section is to assess the degree of competition among insurers and providers in the state. We also evaluate how competition is affected by the various mechanisms used by the state to regulate the health care market place is also evaluated. Lewin's analysis is presented in the following sections:

? Fundamentals of Competition in the Health System;

? Competition Among Insurers in Vermont;

? Competition Among Hospitals in Vermont; and

? The Impact of Health System Regulation on Competition.

### *1. Fundamentals of Competition in the Health System*

Experience in states with highly competitive insurance markets shows that having a large number of insurers in a market area is not enough to result in substantial price competition in insurance. For competition to be effective, there must be a high degree of competition among

[4] "Reviving Health Insurance in Vermont", Ethan Allen Institute, April 2000.

providers as well. This is because the key to price competition among insurers is their ability to reduce their premiums by negotiating favorable terms with competing hospitals and other providers. Thus, without competition among providers in a market area, insurers can do little to make themselves more price competitive.

For example, consider a city with two competing hospitals. In this environment, an insurer can negotiate volume discounts with one of these hospitals by offering to channel all of their members to that that hospital in exchange for a price discount. The insurer's bargaining leverage in these negotiations is the possibility that if the hospital does not provide a favorable discount, the insurer would take their full volume of patients to the other hospital. The credibility of the insurer's threat to go to another provider is crucial to the insurer's ability to negotiate lower provider prices. The more people covered by the insurer, the greater the bargaining leverage they have with the provider.[5]

By comparison, in a market area with only one hospital, there is no reason for the provider to negotiate favorable terms with the insurer. This is because patients in that market have only one place to get hospital care and will generally serve all of the insurer's hospital patients' in that market regardless of whether they provide a discount to the insurer. This all but eliminates the insurer's bargaining leverage. Thus competition among providers is essential to price competition among insurers. The more competing providers there are in an area, the more bargaining leverage the insurer will have.

Competition can also exist at the physician level. For example, insurers typically create provider networks where the physicians agree to price discounts in exchange for an increased volume of patients. In this model, the insurer is agreeing to channel their full volume of patients to the provider network in exchange for lower prices.[6] Also, health plans often require that network providers participate in their cost containment initiatives such as disease management.

There are several studies showing that selective contracting among competing providers enrollment results in a sustained reduction in the rate of growth in health spending throughout the community. For example, using California hospital cost data, Robinson has shown that the growth in hospital costs was slowed by about 1.5 percentage points per year for every 10 percent increase in selective contracting enrollment.[7] Also, Zwanziger and Melnick found that the growth in exclusive provider networks in California was associated with reduced hospital cost growth.[8] Similar results were estimated from national data by Welch and by The Lewin

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[5] Bargaining leverage is also affected by the types of health plans the insurer offers. For example, an HMO typically can require participants to use a specific hospital. This strengthens the plan's bargaining leverage by assuring that all participants would use that provider. Less stringent forms of managed care such as PPO and POS only provide financial incentives for patients to use selected facilities, which weakens the insurer's bargaining leverage.

[6] In HMOs, the health plan can restrict patients to using only network providers. In PPO and POS plans, the health plan typically encourages the use of network providers by requiring higher patient cost sharing for use of non-network providers.

[7] Robinson, J.C., "HMO Market Penetration and Hospital Cost Inflation in California," *Journal of the American Medical Association*, 266 (20 November 1991): 2719-23.

[8] Zwanziger and Melnick, "Costs and Price Competition in California Hospitals, 1980-90," *Health Affairs*, Fall 1994.

Group.[9,10] However, it is unclear whether these results are still applicable because of the recent wave of consolidations that has occurred in the health care industry.

The implication of this research for Vermont is that increasing the number of insurers operating in the state would have little impact on premiums. This is because there is not enough competition among providers in the state for health plans to negotiate lower prices through selective contracting and network formation. In fact, as discussed below, the fact that insurers cannot engage in effective hospital selective contracting was cited by some of the insurers that we interviewed as a major reason why there are relatively few insurers operating in the state. Moreover, the lack of provider competition may be a major reason why per-capita health care cost growth in Vermont has been greater than the average growth for the nation and the New England states.

### *2. Competition Among Insurers in Vermont*

In recent years, insurance coverage in the individual and small group markets has tended to be dominated by two or three carriers. For example, BISHCA data indicate that 72.4 percent of all individually purchased (non-group) coverage in Vermont during 2000 was provided by BlueCross BlueShield (BCBS) of Vermont (***Figure 37***). In fact 99.4 percent of individual coverage was attributed to just the five largest carriers in the market.

There is somewhat greater choice of coverage in the small group market. About 47.1 percent of all small group coverage was provided through the Mohawk Valley Health Plan (MVP). About 97.5 percent of small group coverage was provided by the five largest carriers. In addition, 88.3 percent of all coverage for association health plans, which typically includes smaller businesses, was provided through BCBS.

There are more carriers serving the large group insurance market than the small group market. However, the five largest plans in Vermont still comprise about 97.5 percent of the market, with the largest portion of coverage provided by MVP and BCBS.

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[9] Welch, W.P., "HMO Market Share and its Effect on Local Medicare Costs," HMOs and the Elderly, Health Administration Press, Ann Arbor Michigan 1994.

[10] The Lewin Group, Inc., "The Cost of Legislative Restrictions on Contracting Practices: The Cost to Governments, Employers and Families," June 1995.

## Figure 37
## Comprehensive Major Medical Business by Insurance Sector and Market Type in Vermont: 2000

| Carrier | Earned Premium | Lives | Earned Premium Percentage of Total | Earned Premium Cumulative Percentage |
|---|---|---|---|---|
| **Individual (Non-Group) Market** | | | | |
| **BlueCross BlueShield of Vermont** | $16,632,157 | 10,222 | 72.4% | 72.4% |
| **Mutual of Omaha Insurance Company** | $4,098,700 | 4,609 | 17.8% | 90.2% |
| **Nationwide Life Insurance Company** | $936,002 | 591 | 4.1% | 94.3% |
| **Fortis Insurance Company** | $729,644 | 61 | 3.2% | 97.5% |
| **MVP Health Plan, Inc.** | $444,455 | 216 | 1.9% | 99.4% |
| **Other Plans** | $130,329 | 308 | 0.6% | 100.0% |
| **Medical - Individual Market Total** | **$22,971,287** | **16,007** | **100.0%** | **100.0%** |
| **Small Group Market** | | | | |
| **MVP Health Plan, Inc.** | $43,546,287 | 21,163 | 47.1% | 47.1% |
| **Allianz Life Insurance Company of North America** | $20,959,321 | 11,657 | 22.7% | 69.8% |
| **Vermont Health Plan** | $16,447,490 | 7,729 | 17.8% | 87.6% |
| **John Alden Life Insurance Company** | $5,243,883 | 3,834 | 5.7% | 93.3% |
| **BlueCross BlueShield of Vermont** | $3,920,818 | 1,193 | 4.2% | 97.5% |
| **Other Plans** | $2,276,025 | 636 | 2.5% | 100.0% |
| **Small Group Total** | **$92,393,824** | **46,212** | **100.0%** | **100.0%** |
| **Association Health Plans** | | | | |
| **BlueCross BlueShield of Vermont** | $139,625,613 | 66,621 | 88.3% | 88.3% |
| **Vermont Health Plan** | $9,440,525 | 4,093 | 6.0% | 94.3% |
| **Connecticut General Lifer Insurance Company** | $7,846,572 | 2,247 | 5.0% | 99.3% |
| **John Hancock Mutual Life Insurance Company** | $458,455 | 148 | 0.3% | 99.6% |
| **New York Life Insurance Company** | $379,181 | 182 | 0.2% | 99.8% |
| **Other Plans** | $457,320 | 840 | 0.2% | 100.0% |
| **Association/Trust Total** | **$158,207,666** | **74,131** | **100.0%** | **100.0%** |
| **Large Group Plans** | | | | |
| **MVP Health Plan, Inc.** | $76,108,779 | 36,988 | 39.9% | 39.9% |
| **BlueCross BlueShield of Vermont** | $52,223,029 | 25,265 | 27.4% | 67.3% |
| **Vermont Health Plan** | $34,534,816 | 15,718 | 18.1% | 85.4% |
| **Connecticut General Lifer Insurance Company** | $15,684,939 | 19,011 | 8.2% | 93.6% |
| **United Healthcare Insurance Company** | $7,344,415 | 3,258 | 3.9% | 97.5% |
| **Other Plans** | $4,674,258 | 17,020 | 2.5% | 100.0% |
| **Large Group Total** | **$190,570,236** | **117,260** | **100.0%** | **100.0%** |

Source: 2000 Annual Statement Supplement Report, Department of Banking, Insurance, Securities, and Health Care Administration.

A recently available nationwide study of insurance markets permits us to compare the number of carriers serving Vermont with other states in 1997. [11] This study found that Vermont had fewer carriers than other states in New England, which reflects that Vermont is the smallest of these 6 states. The study found that there were a total of 15 carriers serving the group market and 4 serving the individual market in Vermont (***Figure 38***). This compares with 26 carriers serving New Hampshire and Maine, and 55 carriers in Massachusetts at that time. There were 41 carriers in Connecticut and 17 carriers in Rhode Island.[12]

**Figure 38**
**Measures of Competition in Insurance Markets for 1998**

| | | Group Market | | | Individual Market | | |
|---|---|---|---|---|---|---|---|
| **State** | **Total Population** (in thousands) | **Number of Insurers** | **Percentage of Market Held by Three Largest Insurers** | **Insurers per Million People** | **Number of Insurers** | **Percentage of Market Held by Three Largest Insurers** | **Insurers per Million People** |
| **Vermont** | 591 | 15 | 90% | 29.5 | 4 | 92% | 7.9 |
| **New Hampshire** | 1,185 | 26 | 49% | 24.7 | 7 | 65% | 6.7 |
| **Maine** | 1,244 | 26 | 82% | 24.8 | 9 | 87% | 8.6 |
| **Massachusetts** | 6,147 | 55 | 55% | 10.6 | 14 | 85% | 2.7 |
| **Connecticut** | 3,274 | 41 | 46% | 14.4 | 12 | 66% | 4.2 |
| **Rhode Island** | 988 | 17 | 91% | 21.7 | 4 | 97% | 5.1 |

Source: Chollet, Deborah J., Kirk, Adele M., Chon, Marc E., "Mapping State Health Insurance Markets: Structure and Change in the States Group and individual Health Insurance Markets, 1995 - 1997," [Report to the Robert Wood Johnson Foundation (RWJF)], Academy for Health Services Research and Health Policy, December 2000.

It should be noted that the number of carriers serving Vermont and elsewhere has declined since 1997. For example, New Hampshire now has only about 10 carriers in their small group market. This reflects a nationwide trend of mergers and consolidations that has reduced the number of insurers in these markets nationwide.

There was also a greater dispersion of groups across carriers in states with larger populations. For example, about 90 percent of the group market in Vermont was held by the top three carriers, only 46 percent of the Connecticut market was concentrated amount the three largest plans.

The same general pattern is evident in the non-group market. The study reports 4 non-group carriers in Vermont compared with 14 carriers in Massachusetts and 12 carriers in Connecticut. About 92 percent of the non-group market in Vermont was covered by the three largest carriers compared with 85 percent in Massachusetts and 66 percent in Connecticut.

One important observation is that in each state there were substantially fewer carriers in the non-group market than in the group market. This reflects the fact that non-group coverage is widely perceived by insurers to be a complicated high-risk line of business. In fact, after the losses

[11] Deborah Chollet, Adele Kirk, Marc Chon, "Mapping State Health Insurance Markets: Structure and Change in the States Group and Individual Markets, 1995-1997" (Report to the Robert Wood Johnson Foundation (RWJF)), Academy for Health Services Research and Health Policy, December 2000.

[12] Includes insurers in large and small group markets.

sustained by insurers in recent years, there is a general lack of interest among carriers nationwide in pursuing this line of business.

Under the HRSA-funded State Planning Grant, the Steering Committee established a workgroup of representatives of the three largest insurers in the state to better understand the issues from the insurer's perspective. The participants agreed that there is no one reason for the small number of insurers operating in Vermont. Rather, it is a combination of regulatory and market issues. Some of the opinions expressed by insurers are as follows:

? The decline in the number of insurers in the state reflects a nationwide trend of consolidations in the insurance industry and a general reduction in the number of insurers who are interested in staying in the business of health insurance.

? One insurer reported the generally held belief among the insurance industry that for some carriers, Vermont is such a small market that it is not worth the effort or expense to comply with the full range of state regulations. State regulations mentioned include community rating, mental health parity (including the requirement that insurers offering mental health coverage must go through mental health agent licensing) and loss ratio limits. One insurer stated that if it were not for an existing office in the state, that insurer would not be operating in Vermont.

? Entering a highly regulated market for a relatively small number of covered lives is not attractive to most insurers.

? Those companies who were not skilled at actually managing care left the state when they were no longer able to profit from risk selection (i.e. marketing coverage to only lower cost groups).

? Lack of competition among providers makes it difficult to form effective networks. Insurers that enter the Vermont market must be prepared to compete with existing managed care plans (TVHV and MVP) as well as offer other products, "[it's not possible] to come in and pull off just one market segment".

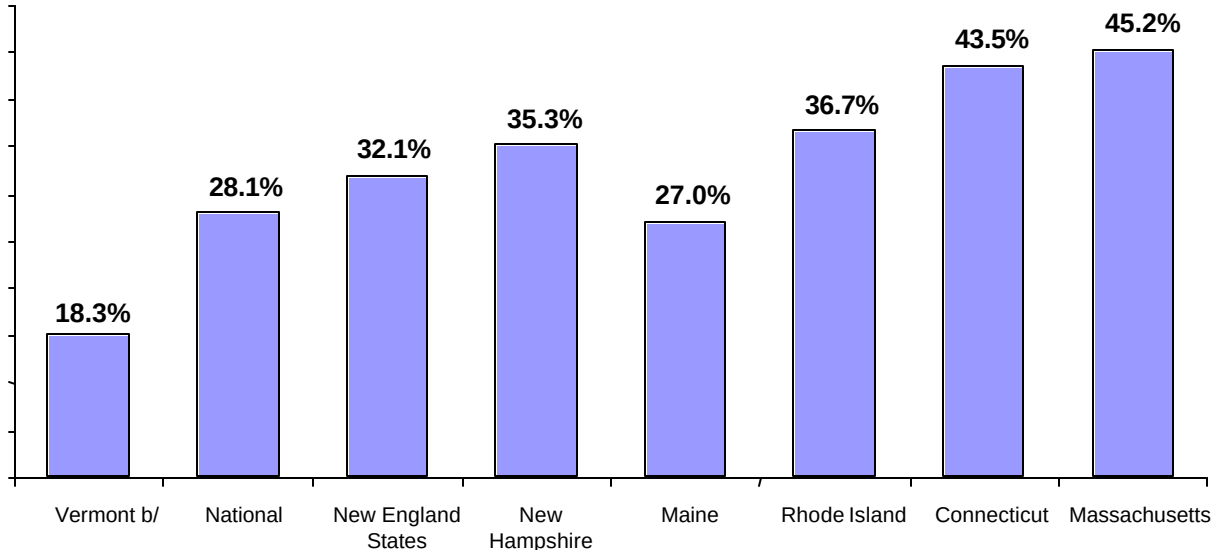
? One participant said that Vermont's aggressive regulatory environment (including community rating, loss ratio limits, mental health parity) has kept large transnational insurance/managed care companies that do business in Maine from entering Vermont.

? Talk of a single-payer system makes insurers uneasy about investing in Vermont.

Participants argued that creating competition through more insurers would not necessarily result in better cost control. This is because, as discussed above, health plans do not have the bargaining leverage to force competition among providers, hospitals and clinicians. This makes it difficult to compete on the basis of controlling costs through effective provider networks. Moreover, cost increases in Vermont are driven primarily by utilization, which is difficult to control in a market with few competing providers (i.e., cost control through selective contracting, etc.).

The limited potential for selective contracting in Vermont is reflected in a relatively low level of HMO enrollment in the state. About 18.3 percent of people in Vermont are enrolled in an HMO (***Figure 39***). This compares with an average of 28.1 percent nationwide and 32 percent in the New England states.[13]

**Figure 39**
**HMO Enrollment as a Percent of the State Population [a/]**




a/ Includes HMO enrollment in Medicare, Medicaid and private health plans.
b/ HMO enrollment in Vermont includes 58,367 people in the Mohawk Valley Health Plan (MVP), 27,540 people in the Vermont Health Plan and 25,445 people in BCBS VHP.
Source: Interstudy, a division of Decision Resources, Inc., "The Interstudy Competitive Edge: Part II: HMO Industry Report, July 1, 2000; and data on HMO enrollment provided by BISCHA

It is important to note that not all forms of managed care are precluded by a lack of competition among providers. For example, plans can pay providers a capitated payment amount for each person to cover the full cost of care provided to these patients. Under this model, the providers have an incentive to control spending. Alternatively, the plan could create a "risk-sharing model" where the provider and the health plan share in any savings or losses resulting from care management. These and other approaches have been used throughout the nation in both rural and urban settings.

### *3. Hospital Competition in Vermont*

In order to assess the competitive environment in Vermont's health care system, Lewin's analysis compares the level of competition among Vermont hospitals to hospitals in other New England area states (Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New

[13] The Interstudy Competitive Edge, Part II: HMO Industry Report", Interstudy a Division of Decision Resources inc.

York, and Rhode Island). To accomplish this, Lewin constructed an "index of competition" by partitioning hospitals into the following categories:

? **Low competition** – 0 to 5 hospitals located within a 10 (or 30) mile radius;

? **Medium competition** – 6 to 10 hospitals located within a 10 (or 30) mile radius;

? **High competition** – 11 or more hospitals located within a 10 (or 30) mile radius.

In Vermont, Maine and New Hampshire all hospitals have "low" levels of competition within a 10-mile radius (***Figure 40***). If the area is expanded to a 30-mile radius, 12 out of 14 hospitals (86 percent) of Vermont hospitals have "low" levels of competition (***Figure 41***) Results from this analysis indicate that Vermont hospitals experience a lower level of competition than other New England hospitals.

**Figure 40**
**Level of Competition Among Hospitals Within a 10-Mile Radius**

| | Index of Competition | | | |
|---|---|---|---|---|
| **State** | **Low** | **Medium** | **High** | **Total** |
| **Connecticut** | **28** | **1** | | **29** |
| **Maine** | **34** | | | **34** |
| **Massachusetts** | **46** | **4** | **13** | **63** |
| **New Jersey** | **34** | **6** | **29** | **69** |
| **New York** | **108** | **26** | **52** | **186** |
| **New Hampshire** | **25** | | | **25** |
| **Rhode Island** | **7** | **3** | | **10** |
| **Vermont** | **14** | | | **14** |
| **Total** | **296** | **40** | **94** | **430** |

Source: Lewin Group analysis using the ESRI Data & Maps CD (July 1999).

According to the Medicare Payment Advisory Commission's (MedPAC) state-by-state analysis of hospital private payment-to-cost ratios, Vermont has a payment-to-cost ratio of 122.4, indicating that private payments are higher than costs for Vermont hospitals (***Figure 42***). Vermont ranks 28$^{th}$ in the nation, and has a higher payment-to-cost ratio than the United States average (112.3).

However, private payment-to-cost ratios are not consistently high across all the New England states. Connecticut, Massachusetts, and Rhode Island have low private payment-to-cost ratios (106.9, 96.4, and 92.4 respectively). In fact, Rhode Island and Massachusetts have the lowest private payment-to-cost ratios in the United States, with Rhode Island ranking 1$^{st}$ and Massachusetts ranking 2$^{nd}$ in the nation. In contrast, Maine, New Hampshire, and Vermont have high private payment-to-cost ratios (139.1, 122.5, and 122.4 respectively). Overall, 4 out of the 6 (Connecticut, Maine, New Hampshire, and Vermont) New England states have higher private payments relative to costs.

**Figure 41**
**Level of Competition Among Hospitals Within a 30-Mile Radius**

| | Index of Competition | | | |
|---|---|---|---|---|
| **State** | **Low** | **Medium** | **High** | **Total** |
| **Connecticut** | 3 | 5 | 21 | 29 |
| **Maine** | 30 | 4 | | 34 |
| **Massachusetts** | 9 | 7 | 47 | 63 |
| **New Jersey** | 4 | 6 | 59 | 69 |
| **New York** | 47 | 44 | 95 | 186 |
| **New Hampshire** | 9 | 12 | 4 | 25 |
| **Rhode Island** | 1 | 2 | 7 | 10 |
| **Vermont** | 12 | 2 | | 14 |
| **Total** | **115** | **82** | **233** | **430** |

Source: Lewin Group analysis using the ESRI Data & Maps CD (July 1999).

### *4. Competition Among Physicians in Vermont*

As discussed below, on a per-capita basis, the supply of physicians in Vermont is higher than in most other states. Ordinarily, this would suggest that there is significant potential for competition among physicians in Vermont markets. There are several physician networks in Vermont, the largest of which is sponsored by BCBS of Vermont. Health plans have been able to negotiate some discounts with physicians through networks. However, insurers report that there is relatively little price competition among physicians in the state.

One of the primary reasons for this is that Vermont is largely rural. Many physicians are located in areas where they are the only provider in the area, which limits the bargaining leverage that health plans have in negotiating volume discounts. Also, while Vermont has a high number of physicians on a per-capita basis, these providers are mal-distributed within the state. This is true for both primary care physicians and specialists. In fact, as discussed below, a number of areas in Vermont are designated as "health professional shortage areas."

As a consequence, health plans have little bargaining leverage with providers. This is particularly true of some physician specialists. This is because the state population is barely large enough to support more than one or two sub-specialists throughout the state. This results in provider shortages in the areas where these providers are not located. Moreover, it leaves the health plans with little leverage in negotiating reimbursement rates with the very specialists that account for some of the most expensive types of treatments.

There are three other significant barriers to forming networks in the state. First, insurers do not consider physician payment rates to be particularly high in Vermont, which limits the amount of savings that they could expect to realize through network formation. Second, a number of the hospitals in the state have established physician practices, which, due to the lack of competition among hospitals, reduces the health plan's bargaining leverage with these physicians. Third, the inability of health plans to negotiate selective contracting arrangements with hospitals is sufficiently limiting that it reduces the potential for savings through selective contracting in general.

**Figure 42**
**Hospital Private Payment-to-Cost Ratios by State, 1999**

| Rank | State | Payment-to-Cost Ratio | Rank | State | Payment-to-Cost Ratio |
|---|---|---|---|---|---|
| **1** | RI | 92.4 | **26** | FL | 122.1 |
| **2** | MA | 96.4 | **27** | OK | 122.3 |
| **3** | NY | 96.9 | **28** | **VT** | **122.4** |
| **4** | PA | 100.9 | **29** | NH | 122.5 |
| **5** | WA | 105.2 | **30** | NC | 124.8 |
| **6** | MI | 106.2 | **31** | WI | 125.4 |
| **7** | CT | 106.9 | **32** | KY | 125.6 |
| **8** | AZ | 108.3 | **33** | ND | 127.5 |
| **9** | MD | 109.0 | **34** | IN | 128.7 |
| **10** | OR | 109.9 | **35** | IA | 129.4 |
| **11** | AL | 110.8 | **36** | KS | 129.9 |
| **12** | MO | 111.4 | **37** | NE | 130.1 |
| **13** | CA | 112.6 | **38** | ID | 131.0 |
| **14** | OH | 112.6 | **39** | VA | 131.4 |
| **15** | CO | 112.8 | **40** | MT | 133.0 |
| **16** | NM | 113.9 | **41** | WV | 133.6 |
| **17** | NJ | 114.1 | **42** | GA | 133.7 |
| **18** | MN | 114.9 | **43** | AR | 133.9 |
| **19** | HI | 115.3 | **44** | SD | 136.6 |
| **20** | TN | 117.5 | **45** | ME | 139.1 |
| **21** | IL | 119.9 | **46** | SC | 142.6 |
| **22** | UT | 120.3 | **47** | AK | 143.2 |
| **23** | NV | 120.4 | **48** | WY | 143.4 |
| **24** | DE | 120.7 | **49** | MS | 147.2 |
| **25** | TX | 121.9 | **50** | LA | 166.5 |
| **All Hospitals** | | **(Weighted Average)** | | | **112.3** |

Source: Medicare Payment Advisory Commission (MedPAC), 2001

In 2000, a group that included representatives of state government, the private sector, health plans, and providers issued a Joint Statement on the Health Care System in Vermont. That statement found that physicians do not have the same ability to cost shift that hospitals do. "Both governmental and private payers have established fee schedules, which are rarely subject to negotiation. In some cases, usually Medicare or Medicaid, the fees that are paid are less than the actual cost to provide the service… These physicians may be able to maintain the financial

viability of their practices by limiting the number of patients covered by payers who pay less than costs. This limitation can produce access problems for those patients."[14]

According to the Vermont Department of Health in the two years between 1996 and 1998, the percentage of primary care practice sites that accepted new Medicaid patients dropped 5 percent. In the same two-year period, the percentage of pediatricians accepting new Medicaid patients declined from 98 percent to 92 percent. Medicaid access to family practitioners declined from 81 percent to 76 percent and access to internal medicine physicians dropped from 78 percent to 73 percent.[15]

## *5. The Impact of Health System Regulation on Competition*

The state of Vermont regulates several aspects of the health care system, which impacts on the nature of competition in the Vermont health care system. For example, the state has required guaranteed issue of insurance and community rating of premiums in for insurers operating in the state. Insurers are also required to cover certain services under all health plans sold in the state. The state also conducts an annual budget review process for the 14 hospitals in Vermont. In addition, hospitals and nursing homes must obtain a Certificate Of Need (CON) for any major capital improvements or expansions.

### *a. Mandated Benefits*

The state requires plans to cover a range of services under each policy sold in the state. Some of these mandates are in statute and some have been specified by BISHCA under regulatory authority granted by the legislature. These mandated services include maternity care, mental health care and substance abuse care and other services shown in ***Figure 43***. In addition, the state requires mental health parity, which means that mental health services are covered with no greater cost sharing requirements than is required for other services under the plan.

It is generally believed that mandated benefits increase premiums resulting in lower levels of coverage. However, it is difficult to estimate the impact of these mandates. The reason for this is that consumers can respond to these premium increases by purchasing less comprehensive coverage, thus enabling them to continue to have insurance. For example, consumers could purchase a plan with higher coinsurance and reduced coverage for other services to avoid paying a higher premium due to the mental health parity provisions.

One of the insurers interviewed indicated that their data showing that mandatory benefits (e.g., chiropractic and mental health, including the requirement that insurers offering mental health coverage must go through mental health agent licensing) have increased insurance premiums in the state by 5 to 10 percent. Mental health parity is also believed to have had a significant financial impact.

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[14] Joint Statement on the Health Care System in Vermont, June 1, 2000, page 12

[15] 1998 Survey Report, Health Care Professional Profiles, Vermont Department of Health;
1996 Physician Survey, Vermont Health Care Provider Profiles, Vermont Department of Health

**Figure 43**
**Summary of Vermont Health insurance Mandated Benefits**

| Requirements | Citation |
|---|---|
| **Rates & Forms Prior Approval** | 8 V.S.A. §4062 |
| **Trust & Association Approval** | §4079 |
| **Certificates Required (Group only)** | §4080(2) |
| **Part Time Employees (Group only)** | §4080(4) |
| **Mental Health/Substance Abuse Parity** | §4089b |
| **Diabetic Care** | §4089c |
| **Disabled Child Coverage** | §4090 |
| **Continuation & Conversion (Group only)** | §4090 |
| **Termination & Replacement (Group only)** | §4091 |
| **Extension of Benefits** | §4091 |
| **Well Baby Care** | §4092 |
| **Home Health Care** | §4096 |
| **Mammography Coverage** | §4100 |
| **Craniofacial Disorders** | §4089g |
| **Metabolic Diseases** | §4089e |
| **Maternity Coverage** | Regulation 89-1 & Bulletin 114 |
| **Chiropractic Coverage** | §4088a |
| **Independent External Review** | §4089f |
| **Contraceptive Coverage** | §4099c |
| **Growth Cell Stimulation Factor** | §8079e |

Source: Division of Health Care Administration.

While consumers may have adjusted by changing other aspects of their coverage, it is likely that these mandates have resulted in at least some premium increases. These premium increases are also likely to have caused at least some individuals to drop their coverage entirely. For example, in a recent study of the effect of premium increases on coverage, Lewin estimated that every five-percentage point increase in premiums is associated with a one-percent reduction in the number of people with health insurance.[16]

### *b. Insurance Market Regulation*

In 1992, the Vermont Legislature enacted legislation to regulate the sale of health insurance in the individual and small group markets. Insurers operating in the state in these markets must guarantee issue of insurance to all applicants regardless of health status. Insurers were also required to adopt a modified community rating process where premiums are equal to the carrier's average costs in these markets.

[16] John Sheils, et al. "Exploring the Determinants of Employer Health insurance Coverage", (Report to the AFL-CIO), 1998

Premium variation with the health status of the individual was prohibited. Initially, plans were permitted to vary the premium within a range of 25 percent of the average premium by participant characteristics. However, this 25 percent premium variation is currently being phased-out in the small-group market so that all participants would pay the same premium. The insurers interviewed indicated that community rating increased premiums for their younger–healthier groups while decreasing premiums for their older-sicker groups, but had little effect on the overall average premium.

The purpose of community rating is to pool the risk of insurance across the market so that all individuals and small groups can be guaranteed coverage at a uniform premium level regardless of health status. However, there are two ways in which this pooling of risk can be undermined.

? First, employer associations are permitted to offer coverage where the premium is based upon cost experience for the group rather than the community rate; and

? Second, some small groups have been able to self-insure with the help of a reinsurance policy covering high cost cases.[17]

Both the association and self-insured models permit groups with a comparatively healthy workforce to escape the community rate. They also permit employer groups to rejoin the community rated pool once their workforce ages or starts to experience large claims. All of this increases premiums in the community rated pool, thus making it more difficult for other groups to obtain coverage.

The insurers interviewed expressed concern over the effect that self-insurance is having on the community rated pool. One participant said that "selection behavior" has "polluted" the community rated risk pool in Vermont. Despite this problem, these insurers also felt that community rating has helped to "level the playing field" for BCBS and the HMOs. This is because prior to this legislation, BCBS and HMOs were the only health plans required to community rate. Leveling the playing field caused some carriers to think about leaving the state, because once community rating was established, the most desirable target groups weren't as easily accessible.

As discussed above, community rating is only one of the reasons that some carriers left the state. The inability to form competitive networks in the state is a major impediment to competition among health plans. Moreover, the high loss experience of insurers in recent years has led to a reduction in the number of carriers in the individual and small group markets throughout the nation.

[17] Under the Employee Retirement Income Security Act (ERISA), states are prohibited from regulating employee welfare plans. This has been interpreted to mean that states are prohibited from regulating self-funded health plans, (i.e., plans where the employer bears the risk for covered services) but are permitted to regulate health insurance (i.e., plans where the insurer bears the risk for covered services). Because larger firms are better positioned to accept risk for covered services, most large employers are self-funded while most smaller groups are fully insured.

### c. *Hospital Budgeting and Certificate of Need*

The state conducts an annual budgetary review for Vermont hospitals and the state must approve all capital improvements and expansions through a Certificate of Need (CON) Process. However, these processes are believed to have done little to control the growth in hospital costs in the state. For example, as discussed above, per-capita hospital spending in Vermont grew at an annual rate of 5.4 percent per year between 1990 and 1998, compared with an annual rate of 4.1 percent in the New England states and 4.0 percent nationwide.

A cross-state comparison of hospital costs per adjusted admission showed that Vermont hospital costs were high relative to hospitals in other New England states and the nation. (***Figure 44***). The average cost per adjusted hospital admission was $6,719 in Vermont in 1998, which was second highest in the New England region behind Connecticut ($7,323). The average cost per adjusted admission in Vermont ranked 41st nationally (the state with a rank of one had the lowest cost and the state with a rank of 51 had the highest cost). After standardizing for factors outside of hospital management control (such as population characteristics, percent rural, etc.), Vermont's ranking by average costs per adjusted admission improved to 30. After adjusting for factors outside of the hospital's control, costs in Vermont hospitals are slightly above the median for the nation.

**Figure 44**
**Hospital Margin, Hospital Costs Per Adjusted Admission and Staff Per Adjusted Admission in 1998**

| State/Region | Hospital Margin 1999 a/ | Cost Per Adjusted Admission b/ | | | Total Staff Per 1,000 Adjusted Admissions | | |
|---|---|---|---|---|---|---|---|
| | | Average | State Rank | | Average | State Rank | |
| | | | Unadjusted | Adjusted | | Unadjusted | Adjusted |
| **Vermont** | 2.5% | $6,719 | 41 | 30 | 76 | 27 | 17 |
| **New England** | 2.1% | $6,576 | NA | NA | 76 | NA | NA |
| **Maine** | 7.2% | $6,311 | 32 | 44 | 77 | 34 | 38 |
| **New Hampshire** | 9.4% | $6,118 | 29 | 8 | 76 | 29 | 31 |
| **Massachusetts** | 0.3% | $6,447 | 34 | 4 | 76 | 28 | 26 |
| **Connecticut** | 2.3% | $7,323 | 45 | 25 | 74 | 36 | 28 |
| **Rhode Island** | -1.9% | $6,539 | 37 | 24 | 73 | 22 | 34 |
| **U.S. Average** | -- | $6,243 | NA | NA | 75 | NA | NA |

a/ Hospital margin is defined as the difference between hospital revenues and expenses as a percentage of revenues.
b/ Cost per Adjusted Admission is defined as total hospital operating expenses divided by number of adjusted admission. Adjusted admissions is the sum of inpatient admission and equivalent admissions attributed to outpatient services (derived by multiplying admissions by the ratio of outpatient revenue to inpatient revenue).
Source: Lewin Group analysis of the Medicare Hospital Cost Report Data for 1998

However, the relatively high costs for Vermont hospitals was not a result of over staffing. After adjusting for factors outside the hospitals control, Vermont hospital ranked 17th lowest for total staff per adjusted admission. Also, hospital margins in Vermont are generally consistent with

margins in other states. For example, the average margin for Vermont hospitals is 2.5 percent compared with an average of about 2.1 percent in the New England States.

Some of the insurers interviewed suggested that Vermont may not need as many hospitals as it has. One insurer representative voiced the opinion that the Dartmouth-Hitchcock and Fletcher Allen systems, along with 2-3 other hospitals, could cover the inpatient service needs in the state alongside a system of urgent and emergency care facilities. Another suggested that having two medical schools in Northern New England may be too many. The insurer representatives interviewed agreed that it is not the hospital *systems* in Vermont which are the high cost entities but rather the small, rural hospitals.

Workgroup participants generally agreed that changing provider behavior and utilization is the key to cost control. Disease management has been found to be an effective means of controlling beneficiary utilization. The focus for reducing costs in the long term is to influence utilization decisions by providers using: financial incentives (such as "risk sharing"), providing comparison and best practice information, sharing data, disease management strategies, small process interventions, and developing good working relationships with providers.

## F. Cost Shifting

Cost shifting is the practice whereby providers recover the cost of uncompensated care and shortfalls in reimbursement under public programs. The cost shift occurs in three ways. First, uninsured people who do not pay for their care often create an uncompensated care burden for providers that is passed on to other payers, primarily employer group plans, in the form of higher charges. Second, some insured individuals fail to pay coinsurance amounts resulting in bad debt expenses. Third, reimbursement levels under public program such as Medicare and especially Medicaid are often less than the cost of services provided causing payment shortfalls that result in higher charges for privately insured people.

### *1. Measuring the Cost Shift*

The literature is mixed on the magnitude of the cost shift. One possibility is that hospitals and physicians pass on the full amount of uncompensated care and shortfall in public program payments to privately insured people in the form of higher payments (i.e., charges less negotiated discounts). However, there is evidence that not all of these payment shortfalls are passed on to privately insured people. In fact, providers are likely to take steps to reduce costs when faced with payment shortfall. Thus, some of these shortfalls result in a cost shift to the privately insured, while some of it takes the form of reduced spending (e.g., delay capital improvements etc.).

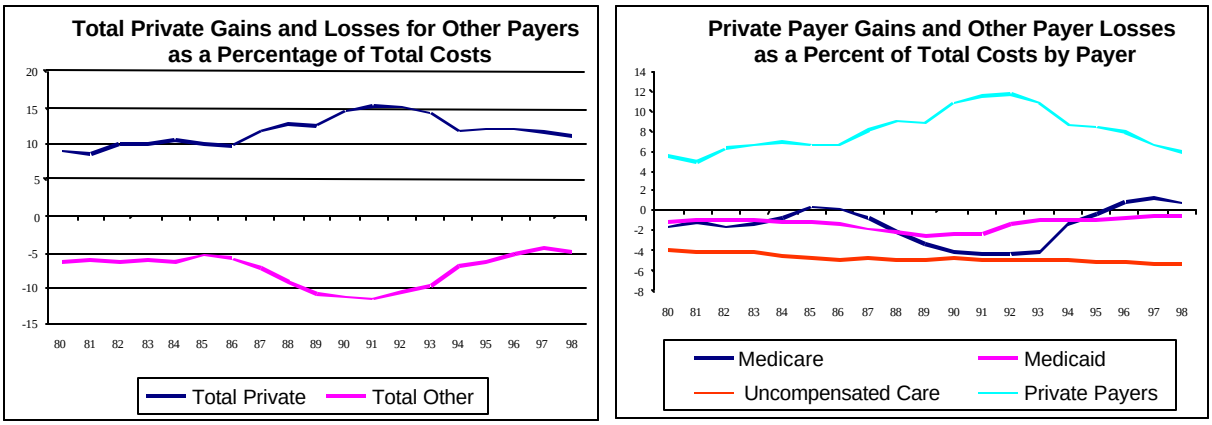
Two independent studies estimated that about half of hospital payment shortfalls are passed on to private payers in the form of higher charges.[18] However, two other studies showed considerably

[18] Dranove, David, "Pricing by Non-Profit Institutions: The Case of Hospital Cost Shifting," Journal of Health Economics, Vol. 7, No. 1 (March 1998); and Sloan, Frank and Becker, Edward, "Cross-Subsidies and Payment for Hospital Care," Journal of Health Politics, Policy and Law, vol. 8., No. 4 (Winter 1984)

less evidence of hospital cost shifting, although they did not rule out a partial cost shift.[19] One study of physician pricing by Thomas Rice et al., showed that for each one percent reduction in physician payments under public programs, private sector prices increased by 0.2 percent.[20] Our own analysis of hospital data indicated that about 40 percent of the change in payment shortfalls in the years studied were passed on to private payers in the form of the cost shift.[21]

Historical data show that private payer costs increase as payment shortfalls rise and decline as payment shortfalls decrease. For example, when Medicare losses (i.e., revenues minus costs) as a percent of total costs increased prior to 1995, private payer gains as a percentage of total costs increased (***Figure 45***).

**Figure 45**
**Aggregate Losses or Gains as a Percent of Total Hospital Costs for Medicare, Medicaid, and Uncompensated Care, 1980-1998 a/ b/**




a/ Private gains include private payer gains (i.e., revenues minus costs) as a percentage of total costs. Private payers include employer-sponsored coverage and individually purchased non-group coverage.
b/ Other payer losses include losses (i.e., revenues minus costs) for Medicare, Medicaid, and uncompensated care as a percentage of total costs.
Source: Lewin Group analysis of data from the American Hospital Association (AHA) survey of hospitals.

This symmetrical relationship between revenues for public and private programs suggests a substantial degree of cost shifting. Moreover, it suggests that increases in public program payments can result in lower costs for private payers. Therefore, the increase in Medicaid reimbursement rates recently passed by the Vermont legislature should help slow the growth in private health plan costs over the next few years. (The Vermont legislature recently adopted

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[19] Zuckerman, Stephen, "Commercial Insurers and All-Payer Regulation," Journal of Health Economics, Vol. 6. No. 2 (September 1987); and Hadley, Jack and Feder, Judy, "Hospital Cost Shifting and Care for the Uninsured." Health Affairs, Vol. 4 No. 3 (Fall 1985).

[20] Rice, Thomas, et al., "Physician Response to Medicare Payment Reductions: Impacts on pubic and Private Sectors," Robert Wood Johnson Grant No. 20038, September 1994.

[21] Sheils J., Gary Claxton, "Potential cost shifting under proposed Funding reductions for Medicare and Medicaid: The Budget Reconciliation Act of 1995," (Report to the National Coalition on Health Care), the Lewin Group, December 6, 1995

legislation that would increase VHAP payment rates to Medicare levels, although funds have not yet been appropriated for this purpose).

### *2. Hospital Cost Shifting*

We estimated the amount of hospital cost shifting based upon the budgeted amounts for hospital spending in 2001 negotiated by BISHCA with Vermont hospitals. These budgeted amounts are based upon historical data on revenues and expenses for all Vermont hospitals and are updated to reflect negotiated increases in spending for current year operations. Total operating revenues from all payers are projected to be $856.9 million in 2001 (***Figure 46***). Total operating expenses are projected to be $832.8 million resulting in a net operating surplus of $24.1 million.

**Figure 46**
**Derivation of Hospital Operating Surplus (Deficit) by Payer: Budgeted 2001**
**(in thousands)**

| | Gross Revenues | Net Patient Revenues | Operating Revenue b/ | Operating Expenses c/ | Operating Surplus (Deficit) d/ | Payment to Cost Ratio |
|---|---|---|---|---|---|---|
| **Total** | **$1,301,109** | **$837,560** | **$856,927** | **$832,784** | **$24,143** | **1.03** |
| **Medicaid** | $131,820 | $85,362 a/ | **$87,324** | $105,227 | **($17,903)** | **0.83** |
| **Medicare** | $460,766 | $261,747 | **$268,605** | $286,698 | **($18,093)** | **0.94** |
| **Commercial** | $655,481 | $490,451 | **$500,208** | $407,854 | **$92,354** | **1.23** |
| **Free Care** | $18,570 | $0 | **$276** | $11,556 | **($11,280)** | **N/A** |
| **Bad Debt** | $34,472 | $0 | **$514** | $21,449 | **($20,935)** | **N/A** |

a/ Includes projected Medicaid payments ($60,492) plus disproportionate share hospital payments ($24,970).
b/ Includes net patient revenues plus a pro-rata share (based on percentage of gross revenues by payer) of other operating revenue.
c/ All operating expenses except provider tax payments are distributed across payers based upon the distribution of gross revenues by payer. The full amount of provider tax payments is counted as a Medicaid expense.
d/ Equals operating revenues minus operating expenses.
Source: Lewin Group estimates.

However, only commercial payers will pay more than costs. Total operating revenues from commercial payers will be $500.2 million, which exceeds projected expenses for this population ($407.9 million) by $92.3 million. This surplus will be largely offset by operating losses under Medicaid and Medicare, and bad debt and charity care expenses.

For example, expenses for Medicaid patients would be 105.2 million, which would be about $17.9 million greater than Medicaid revenues ($87.3 million).[22] Thus, Medicaid payments are equal to about 83 percent of costs. The shortfall in hospital reimbursement under Medicare would be about $18.1 million. This is the amount by which total operating revenues for Medicare patients ($268.6 million) will be less than total expenses for this population ($286.7 million).

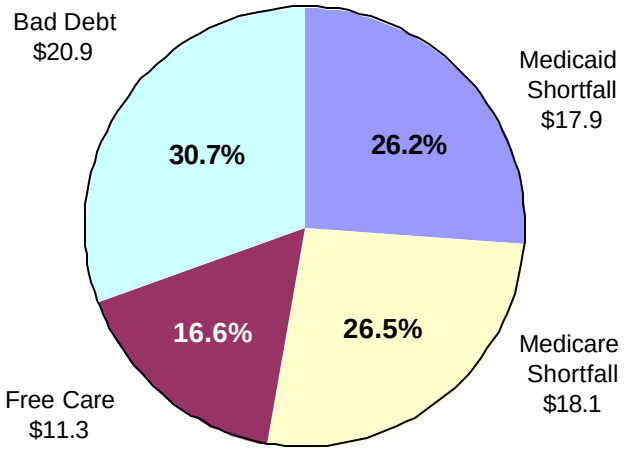
[22] Medicaid Disproportionate Share Hospital (DSH) payments to hospitals ($24.9) are counted as Medicaid revenues while the hospital provider tax payments used to pay for the DSH program ($23.7) are counted as Medicaid expenses.

Medicare payments in Vermont are equal to about 94 percent of costs. In addition, there will be about $11.3 million in charity care and about $21.4 million in bad debt.

Payments in excess of costs for commercially insured people would be $92.3 million in 2001. Of this, $68.2 million will go to offset underpayments by other payers. Thus, the total amount of costs shifted to private payers in 2001 would be $68.2 million. The remaining $24.1 Million would comprise the hospital surplus (i.e., profit, hospital margin etc.) for that year.

As shown in ***Figure 47***, the Medicaid/VHAP program accounts for about 26.2 percent of the hospital cost shift in Vermont. Medicare accounts for 26.5 percent of the cost shift, with charity care accounting for only about 16.6 percent. The largest share of the hospital cost shift is attributed to bad debt, which is typically composed of unpaid coinsurance amounts for insured people.

**Figure 47**
**Hospital Cost Shift by Source of Shortfall in 2001 (in millions)**




**Total Hospital Cost Shift = $68.2 million**

Source: Lewin Group estimates.

Hospital cost shifting in Vermont appears to be proportionally greater that in the rest of the country. The ratio of private payments to costs in Vermont in 1999 was 1.22, which means that commercial payers are paying about 22 percent in excess of costs for privately insured people (***Figure 48***). By comparison, the average private payment-to-cost ratio nationwide is only 1.12 nationwide, and an average of 1.03 across New England states.

**Figure 48**
**Hospital Private Payment-to-Cost Ratios, 1999**

| State | Private Payment-to-Cost Ratio |
|---|---|
| **Vermont** | 1.22 |
| **New England** | 1.03 |
| **United States** | 1.12 |

Source: Medicare Payment Advisory Commission (MedPAC), 2001.

### 3. *Physicians and Other Providers*

Medicaid and VHAP payment rates for services provided by physicians and other providers are typically lower than under both Medicare and private health plans. For example, a recent study conducted by the Urban Institute showed that, nationwide, payment rates for 22 commonly provided services under Medicaid were on average equal to about 64 percent of Medicare payment rates for the same services.[23] Private payer rates for these services also can be greater than Medicare rates by 20 percent or more. Thus the disparities in payment levels under Medicaid are quite substantial.

Medicaid/VHAP/Dr. Dynasaur physician payment rates in Vermont are equal to about 69 percent of Medicare payment rates for the state (***Figure 49***). This is greater than the national average of 64 percent, and the New England average of 63 percent. It should be noted that Vermont's Medicare payment rate is one of the lowest in the country. Payment rates as a percentage of Medicare rates in New England states were highest in Massachusetts.

**Figure 49**
**Summary Comparison of Medicaid Payments for Selected Non-Hospital Services** [a/]

| | Percentage Difference from National Average [b/] | Medicaid Payments as a Percentage of Medicare Payments |
|---|---|---|
| **Vermont** | **10%** | **69%** |
| **New England** | **7%** | 63% |
| **New Hampshire** | 21% | 67% |
| **Maine** | -4% | 66% |
| **Rhode Island** | -33% | 44% |
| **Connecticut** | 51% | 64% |
| **Massachusetts** | -2% | 71% |
| **U.S. Average** | **N/A** | **64%** |

a/ Estimates based upon a comparison of rates for 22 widely performed procedures.
b/ Index is equal to the ratio of average Medicaid payments in each state to average Medicaid payments nationally.
Source: Norton, Stephen, "Recent Trends in Medicaid Physician Fees, 1993 - 1998," Discussion paper, Urban Institute, September, 1999.

While Medicaid payment rates are low compared to other payers, the Medicaid payment levels in Vermont are actually greater than in most states. The Urban Institute study showed that payment rates in Vermont are about 10 percent higher than the national average. By comparison, payment rates in New England states are on average 7 percent greater than the national average (***Figure 49***).

[23] Stephen Norton, "Recent Trends in Medicaid Physician Fees, 1993-1998", Urban Institute, Discussion Paper, September 1999.

### 4. Consequences of Cost Shifting

The consequences of cost shifting differ among health care sectors, depending on regulatory and competitive forces. Hospitals have some capacity to raise their charges to selected payers to offset inadequate reimbursement by others. Among other effects, this response raises charges to health insurers, self-insured employers, and uninsured individuals above what they would be in the absence of the cost shift.

Individual providers, such as physicians and dentists, are almost always reimbursed through fee schedules that are established by both public and private payers and are not subject to negotiation. The exceptions to this are very large physician practices or specialty practices upon which geographic areas are highly dependent. Because of this reimbursement system, individual providers have a minimal capacity to shift costs. For these providers, the likely consequences include financial jeopardy to practices or limitations on access to care.[24]

### 5. The Cost of Increasing Physician Reimbursement

The Vermont Medical Society, with the assistance of economists from the American Medical Association, has developed an estimate of how much it would cost to increase Medicaid physician reimbursement to Medicare levels. Data for this analysis was supplied by the Office of Vermont Health Access (OVHA).

While there are some issues related to data availability, the re-pricing methodology used was optimal. Physician reimbursement is based on a system called Current Procedural Terminology (CPT). Under the CPT system, each different medical service has a unique identification number. Under most reimbursement systems, including both Medicare and Medicaid, each CPT code has a specific reimbursement associated with it (although this may occasionally vary by physician specialty or type of patient). Thus, it is a straightforward process to calculate for each CPT code how much was received from Medicaid and how much would have been received if Medicaid used Medicare reimbursement.

The difficulty arises because during the period for which the data was available, the two managed care plans were responsible for a significant proportion of the care received by Medicaid beneficiaries. Information on services provided through managed care arrangements was not available.

For all services included in the analysis, to obtain equal reimbursement an additional $3.56 million (or 26.85 percent) would be necessary (***Figure 50***). OVHA applied this percentage to its projected FY02 physician claims after removing "crossover" claims. Crossover claims are those for services provided to individuals with both Medicare and Medicaid coverage. These claims are already paid at Medicare levels. OVHA estimates that $11 million will be necessary to bring its payments to Medicare levels.

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[24] *Staff Report to the Joint Fiscal Committee on the Medicaid Cost Shift in Vermont***,** Prepared pursuant to Act 152, §117b, 2000 session adjourned

## Figure 50
## The Cost of Adjusting Physician Payments under Medicaid to Medicare Levels

| | OVHA ANALYSIS CY 2000 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Specialty | Billed Amount | Allowed Amount | Allowed to VMS ratio | Adjusted Medicaid at Medicare rate | Medicare as % of Charges | Medicaid Allowed % of Charges | Medicaid Allowed as % of Medicare | Amount necessary to get Medicaid to Medicare |
| General Practice | $33,085,392 | $11,093,447 | 0.287 | $16,094,122 | 48.6% | 33.5% | 68.9% | $5,000,676 |
| Obstetrics/Gynecology | $7,008,822 | $3,693,129 | 0.296 | $4,367,092 | 62.3% | 52.7% | 84.6% | $673,962 |
| Pediatric Medicine | $5,026,213 | $3,561,224 | 0.178 | $5,658,565 | 112.6% | 70.9% | 62.9% | $2,097,342 |
| Family Practice | $4,417,201 | $2,709,493 | 0.354 | $4,117,651 | 93.2% | 61.3% | 65.8% | $1,408,158 |
| Diagnostic Radiology | $2,950,526 | $1,135,531 | 0.275 | $1,041,178 | 35.3% | 38.5% | 109.1% | -$94,353 |
| Orthopedic Surgery | $2,748,864 | $779,109 | 0.263 | $1,324,141 | 48.2% | 28.3% | 58.8% | $545,031 |
| Internal Medicine | $2,372,823 | $1,364,951 | 0.216 | $2,054,178 | 86.6% | 57.5% | 66.4% | $689,227 |
| Anesthesiology | $2,186,467 | $619,258 | 0.338 | $608,643 | 27.8% | 28.3% | 101.7% | -$10,616 |
| Psychiatry | $2,149,118 | $1,145,004 | 0.375 | $1,804,090 | 83.9% | 53.3% | 63.5% | $659,086 |
| General Surgery | $1,901,230 | $572,039 | 0.319 | $896,698 | 47.2% | 30.1% | 63.8% | $324,659 |
| Ophthalmology | $1,159,501 | $527,938 | 0.348 | $1,078,904 | 93.0% | 45.5% | 48.9% | $550,966 |
| Otolaryngology | $999,189 | $346,916 | 0.242 | $526,843 | 52.7% | 34.7% | 65.8% | $179,927 |
| Cardiology | $854,270 | $307,686 | 0.405 | $510,344 | 59.7% | 36.0% | 60.3% | $202,657 |
| Neurology | $580,173 | $248,179 | 0.324 | $309,998 | 53.4% | 42.8% | 80.1% | $61,819 |
| Urology | $578,459 | $193,809 | 0.281 | $309,798 | 53.6% | 33.5% | 62.6% | $115,990 |
| Pathology | $470,364 | $191,453 | 0.298 | $158,983 | 33.8% | 40.7% | 120.4% | -$32,470 |
| Gastroenterology | $291,220 | $108,307 | 0.370 | $154,507 | 53.1% | 37.2% | 70.1% | $46,199 |
| Podiatry | $195,044 | $78,616 | 0.004 | $146,638 | 75.2% | 40.3% | 53.6% | $68,022 |
| Dermatology | $189,055 | $92,160 | 0.272 | $154,543 | 81.7% | 48.7% | 59.6% | $62,383 |
| Allergy/Immunology | $178,543 | $97,808 | 0.218 | $138,420 | 77.5% | 54.8% | 70.7% | $40,612 |
| Osteopath Manip Therapy | $123,546 | $73,746 | 0.323 | $137,231 | 111.1% | 59.7% | 53.7% | $63,486 |
| Physical Med And Rehab | $106,485 | $39,571 | 0.217 | $56,401 | 53.0% | 37.2% | 70.2% | $16,830 |
| Neurosurgery | $87,213 | $33,781 | 0.271 | $42,458 | 48.7% | 38.7% | 79.6% | $8,677 |
| Hand Surgery | $52,414 | $14,263 | 0.140 | $26,155 | 49.9% | 27.2% | 54.5% | $11,892 |
| Pulmonary Disease | $31,848 | $12,133 | 3.558 | $15,120 | 47.5% | 38.1% | 80.2% | $2,987 |
| Hematology/Oncology | $24,040 | $10,086 | 0.032 | $16,493 | 68.6% | 42.0% | 61.2% | $6,407 |
| Cardiac Surgery | $13,515 | $4,677 | 0.348 | $4,203 | 31.1% | 34.6% | 111.3% | -$473 |
| Plastic Surgery | $9,755 | $2,474 | 0.485 | $5,205 | 53.4% | 25.4% | 47.5% | $2,731 |
| Emergency Medicine | $1,142 | $618 | 1.515 | $730 | 63.9% | 54.1% | 84.7% | $111 |
| Nephrology | $333 | $171 | 0.416 | $274 | 82.2% | 51.3% | 62.3% | $103 |
| Endocrinology | | | | | | | | $0 |
| **Grand Total** | **$69,792,765** | **$29,057,575** | **0.284** | **$41,586,700** | **59.6%** | **41.6%** | **69.9%** | **$12,702,030** |

a/ Actual Medicaid payment is allowed amount less copay and other insurance payments.

Using calendar 2000 claims payments, JFO estimates that an additional $12.7 million would be necessary to bring Medicaid reimbursement to Medicare levels. The difference between the OVHA and JFO estimates arise from how claims missing from the VMS/AMA analysis were estimated.

One minor question in this analysis is how age-specific fees were evaluated. For some services, Medicaid pays a higher rate for children than it does for adults. This factor needs further evaluation, but should have a minimal effect on the final estimate[25].

### *6. The Effect of Provider Payment Increases*

A central question in the cost shift is whether increases in provider reimbursement under Medicaid/VHAP/Dr. Dynasaur would translate into savings for commercially insured people. As discussed above, the available research indicates that increases in provider reimbursement under public programs are associated with reduced cost shifting. This usually takes the form of a slower rate of increase in private payer payment levels.

However, the impact that this will have on private payer costs is limited by the fact that Medicaid/VHAP/Dr. Dynasaur accounts for only a portion of the cost shift. For example, as discussed above (***Figure 47*** above), Medicaid/VHAP/Dr. Dynasaur payment shortfalls account for only about 26 percent of the cost shift for hospitals. Even if the state were to eliminate these payment shortfalls entirely (i.e., $17.9 million), it would reduce private payer hospital payments for hospital services by only about 3.6 percent. The effect would be similar for physicians and other providers.

However, even these estimates may be high. The reason for this is that they assume providers pass-through the full amount of the increase in Medicaid/VHAP/Dr. Dynasaur reimbursement to private payers in the form of lower charges. In fact, as discussed above, providers are likely to retain a substantial portion of these payment increases either for capital improvements or increased provider income. Thus, the impact of increasing provider reimbursement levels on private payers is likely to be small. However, increasing reimbursement levels may improve provider capacity, improve access to health care or at least slow the erosion of that access.

## G. Provider Capacity

One of the most important issues in this analysis is determining whether providers in Vermont would have the capacity to meet consumer demand once universal coverage is achieved. In 1980, The Graduate Medical Education National Advisory Commission (GMENAC) made recommendations for physician need for the entire population. When updated for primary care and selected specialties in 1990, there was little change to the original recommendations. Vermont has used the 1990 primary care recommendations to assess primary care provider capacity and the need for program development and found them to be fairly consistent with local perceptions and experience.

If the recommendations made by GMENAC in 1980 are still appropriate 20 years later, the current supply of physician providers is probably marginal to adequate for most areas of Vermont to accommodate the increased number of people who would seek health care. Temporal changes since 1980 would suggest that, if anything, these estimates might be somewhat low for

[25] Staff Report to the Joint Fiscal Committee on the Medicaid Cost Shift in Vermont Prepared pursuant to Act 152, §117b, 2000 session adjourned

2001. These changes include the increased proportion of elders in the population, an increase in the number of treatment options available, and higher demand (utilization) for health care.

The purpose of this section is to review the methods used to estimate the supply and distribution of health care providers in Vermont, document the supply and distribution, estimate the potential impact of universal coverage and identify health professional shortage areas and safety net providers. This section also presents estimates of the increase in health services utilization and expenditures in Vermont that would occur if all individuals were to become insured.

### *1. Estimating Physician and Dentist Supply in Vermont*

The Vermont Department of Health, in cooperation with the Vermont Board of Medical Practice, conducts a bi-annual survey of all Vermont licensed physicians in order to determine physician to population ratios and help guide public health policy for the state. The bi-annual survey includes physicians who renewed their license as of December of the survey year; currently data is available for 1992, 1994, 1996 and 1998. Data for 2000 will be available early next year. The surveys that are returned are compared against a list of all physicians who were re-licensed. Follow-up mailings and phone calls are then made to Vermont licensed physicians, who did not return a survey to determine if they are seeing patients in Vermont, and if so, to complete the survey.

Similar bi-annual surveys are conducted in cooperation with the appropriate Licensing Boards for Doctors of Osteopathy, Dentists, Advanced Practice Nurses and Physician Assistants. Survey forms are sent to all providers licensed by one of these Boards as of the date. Follow-up telephone interviews are conducted, as needed.

Included in the survey reports are providers who deliver direct patient care services in Vermont. A substantial number of health care providers maintain Vermont licenses even though they do not practice in Vermont. These providers are excluded from all reports. Federally employed physicians who do not provide patient care outside a federal facility are not required to maintain a Vermont license, and are therefore not included, unless they do have a Vermont license. Physicians and dentists participating in residency programs are not required to maintain a Vermont license, although some choose to do so. Because all residents, clinical fellows and research fellows are practicing in a "student" capacity and are here for only a short period of time, they are excluded from the survey reports.

Participation by health care providers achieves or approaches 100 percent for all specialties. Responses over the years have been remarkably consistent supporting the validity of the results. Overall the surveys conducted by the Vermont Department of Health provide an accurate snapshot of Vermont's health care provider supply. Current census or inter-censal population estimates are used to calculate provider to population ratios.

### *2. Physician to Population Ratios in Vermont*

Vermont as a whole falls well within the guidance provided by GMENAC for the number of physicians and primary care physicians needed to serve the population. The number of general surgeons in Vermont is below the recommendation. As can be seen in ***Figure 51*** the distribution

of physicians is quite variable by health care area (Health Care Areas are based on hospitalization for conditions appropriately treated in community hospitals). Universal access to health care, which is predicted to increase overall utilization by about 3.7 percent, can be expected to have the greatest impact on primary care providers and dentists, with somewhat lesser impact, at least in the short-term on general surgeons and specialty providers.

### *a. Primary Care Physicians*

As seen in ***Figure 51***, Vermont's total supply and distribution of primary care providers is probably adequate to provide services to the additional people who would seek care if universal insurance were available. The supply of specialists as a whole is adequate. Potential problem areas are general surgery where Vermont appears to have a serious shortage; and for primary care in at least the four health care areas with fewer than 70 physicians per 100,000 population.

**Figure 51**
Vermont Physician Supply per 100,000 People — 1998

| | Total | Primary Care | General Surgeons | Specialist (including General Surgeons) | Midlevel to Physician Ratio |
|---|---|---|---|---|---|
| **GMENAC** | 148-185 | 70-90 | 11 | 78-95 | 0.50 |
| **Vermont** | 186 | 76 | 6 | 110 | 0.40 |
| **Brattleboro** | 127 | 79 | 13 | 48 | 0.55 |
| **Central Vermont** | 118 | 62 | 2 | 56 | 0.35 |
| **Copley** | 91 | 75 | 4 | 16 | 0.32 |
| **Fletcher Allen** | 367 | 87 | 12 | 280 | 0.40 |
| **Gifford** | 85 | 72 | 9 | 13 | 0.30 |
| **North Country** | 74 | 58 | 0 | 16 | 0.54 |
| **Northeast** | 89 | 70 | 11 | 19 | 0.54 |
| **Northwest** | 82 | 58 | 7 | 24 | 0.26 |
| **Porter** | 130 | 110 | 8 | 20 | 0.18 |
| **Rutland** | 125 | 66 | 2 | 59 | 0.23 |
| **Southwest** | 129 | 76 | 7 | 53 | 0.57 |
| **Springfield** | 106 | 87 | 10 | 19 | 0.44 |
| **Upper Connecticut Valley** | 108 | 79 | 3 | 29 | 0.23 |

Source: 1998 Survey Report: Health Care Professional Profiles. Vermont Department of Health, 2000

Another concern is the availability of primary care providers to serve the adult population, the largest group of uninsured Vermonters. As shown in ***Figure 52,*** the total number of physicians in Family Practice and Internal Medicine, and in OB/GYN are at the bottom of the range suggested by GMENAC suggesting marginal capacity to add new patients. Further, the GMENAC recommendations assume one-third of care is provided by mid-level providers, yet only four of 13 health care areas have achieved the "standard" ratio in Vermont. Finally, according to the 1998 Survey of physicians, 13 percent of primary care practices statewide were closed to any new patients and 19 percent were closed to new Medicaid and/or Medicare patients.

**Figure 52**
Vermont Primary Care Providers per 100,000 People — 1998

| | Family Practice | Internal Medicine | Total FP and IM | Pediatrics | OB/GYN |
|---|---|---|---|---|---|
| **GMENAC** | 28-36 | 25-30 | 53-66 | 7-15 | 8-10 |
| **Vermont** | 32 | 22 | 54 | 14 | 8 |

Source: 1998 Survey Report: Health Care Professional Profiles. Vermont Department of Health, 2000

Estimates of primary care physician requirements, provided by GMENAC are supported by other studies. GMENAC shows a need for an average of 80 primary care physicians (Family Practice, General Internal Medicine, Pediatrics, Obstetrics/Gynecology) per 100,000 population is needed to meet the medical needs of the population (range 70 to 90 per 100,000). The physician requirements are derived from a medical need model. This modeling approach identifies a requirement for physicians consistent with providing ideal levels and types of medical care to meet the needs of the population without regard to the typical barriers posed by ability to pay, access, availability etc. It does not consider the demand for care.[26]

In 1990 the GMENAC standards were re-examined through research sponsored by the Bureau of Health Professions (BHPr) in support of activities of the Council on Graduate Medical Education (COGME). This re-examination concurred with the original supply recommendations made in 1980 and projected needs through 2010.[27] In both years, the physician recommendations assumed that approximately one-third of primary care would be provided by advanced practice nurses or physician assistants. Recommendations by type of primary care provider are also included.[28]

Published reports of staffing ratio's of Health Maintenance Organizations provide further support for this level. Target ratios of physician requirements, made by staff and group model health maintenance organizations range between 1,500 and 2,000 members per primary care physician, not including OB/GYN, with a mean and median of 1,713 and 1,800 respectively (A population to physician ratio of 1500:1 is equivalent to a physician to population ratio of 67 per 100,000). These ratios account for use of Physician Assistants and Nurse Practitioners. Staffing patterns in HMOs have been used as a yardstick for national clinical workforce requirements. HMOs can provide accurate data on both staffing and the populations they serve, are staffed to provide comprehensive care to all of their members, and use an efficient mix of generalists and

[26] (U.S.) Graduate Medical Education National Advisory Committee (April 1981). Report of the Graduate Medical Education National Advisory Committee to the Secretary, Department of Health and Human Services; Washington DC

[27] ABT Associates (April 1991). Reexamination of the Adequacy of Physician Supply Made in 1980 by the Graduate Medical Advisory Committee (GMENAC) for Selected Specialties

[28] BHPr/DHPA/DSB. (November 1980). Report on Development of Criteria for Designation of Health Manpower Shortage Areas; Report No. 78-03.

specialists.[29] As a result, these are representative ratios of needed staffing patterns in a primary care service setting.

In 1996, COGME reviewed five studies undertaken to determine projections for physician to population requirements. The review included the GMENAC study which represented a need-based methodology and four studies representing demand-based models. COGME placed special emphasis on the demand-based models based upon the assumption that the health care system would be increasingly dominated by managed care arrangements. The requirements extrapolated from the five studies range from 1,695-1,299 population per primary care physician for the year 2000 and 1,333-1,235 population per primary care physician for the year 2020.[30]

### *b. Dentists*

Vermont is not well situated to meet the projected 4.3 percent increase in utilization of dental services with universal coverage. There are no data comparable to GMENAC for dentist supply. The estimate of the current average nationwide is 1,700 patients per dentist. Statewide, Vermont has 39 primary care dentists per 100,000 population. ***Figure 53*** shows the dentist to population ratio for Vermont Counties. In addition Vermont has an aging dentist workforce with 25 percent of dentists over the age of 55 and 62 percent over age 45. Sixteen percent of general dentistry practices were closed to new patients in 1998 and 48 percent were closed to new patients enrolled in the Medicaid program.

**Figure 53**
Vermont Dentists by County: 1998

| | Dentist per 100,000 | Percentage Over age 55 |
|---|---|---|
| **Vermont** | 39 | 25% |
| **Addison** | 25 | 60% |
| **Bennington** | 45 | 20% |
| **Caledonia** | 46 | 35% |
| **Chittenden** | 45 | 13% |
| **Essex** | 16 | 0% |
| **Franklin** | 24 | 8% |
| **Grand Isle** | 14 | 0% |
| **Lamoille** | 53 | 20% |
| **Orange** | 27 | 33% |
| **Orleans** | 20 | 50% |
| **Rutland** | 42 | 36% |
| **Washington** | 46 | 26% |
| **Windham** | 46 | 42% |
| **Windsor** | 34 | 25% |

Source: 1998 Survey Report: Health Care Professional Profiles. Vermont Department of Health, 2000

[29] T.H. Dial, S.E. Palsbo, C. Bergstein, J.R. Gabel, and J. Weiner, "Clinical Staffing in Staff-and-Group Model HMOs," *Health Affairs, Summer (1995);* 168-180

[30] Council on Graduate Medical Education. Eight Report; *Patient Care, Physician Supply and Requirements; Testing COGME Recommendations.*, Rockville, Maryland; DHHS, November 1996.

### 3. Comparison of Vermont to Other Jurisdictions

A database similar to the one used to calculate Vermont provider to population ratios is not available for New England and the U.S. Thus, for cross-state comparisons, Lewin used the 2001 Area Resource File. This database includes all physicians and dentists that hold current licenses. It is probably less reliable for Vermont, which is believed to have a higher per capita number of licensed physicians who do not see patients than most other states because:

? It is the only state with less than 1 million people with a medical school. This means a high number of physicians who see no patients because they are employed as teachers, administrators and researchers. Many who do see patients, have office hours less than one day per week.

? Another impact of the teaching programs, at both FAHC and at Dartmouth, is that many residents choose to become licensed during their residency while they are working under the direction of a physician. They are then included in a count of licensed physicians.

? Residents and other physicians are quite likely to maintain their Vermont license when they leave to practice in other locales. It is relatively inexpensive and makes a move back to Vermont to practice at any time much easier.

The data shown in ***Figure 54*** indicates that Vermont may be at least as likely to accommodate additional people in our health care system as other states in New England and the U.S. as a whole. This of course assumes that the ratio of patient care to non-patient care physicians is not significantly different in the other jurisdictions.

**Figure 54**
**Physician and Dentist Supply in Vermont, New England, and the United States – 1999** [a/]

| State | Patient Care Physicians per 100,000 | Primary Care Physicians per 100,000 | Dentists per 100,000 |
|---|---|---|---|
| **Vermont** | 186 | 76 | 39 |
| **New England** | 215 | 74 | 45 |
| **United States** | 152 | 56 | 37 |

a/ The number of physicians and dentists in New England and the U.S. was estimated using the AMA Physician Data which is calibrated to match physician counts developed by the Vermont Department of Health
Source: Lewin Group analysis of the 2001 Area Resource File.

### 4. Health Professional Shortage Areas

Though Lewin's analysis of physician supply indicates that there is probably an adequate number of physicians in Vermont, these physicians are poorly distributed across the state. The large proportion of rural areas in Vermont contribute to the mal-distribution of these physicians in Vermont, mainly because physician practice groups are less likely to practice in rural areas. ***Figure 55*** shows the location of the health professional shortage areas (HPSAs) in Vermont

designated to date by the Bureau of Primary Health Care. There are seven primary care HPSAs; two mental health HPSAs and three dental HPSAs. Recent analysis of State Primary Care service areas has identified one additional area that will qualify as a Primary Care HPSA. Work is underway to identify additional dental areas.

The Bureau of Primary Health Care (BPHC), Division of Shortage Designation is charged with designating underserved areas in the United States. As such, their focus is on identifying areas to receive additional resources, not to recommend staffing levels. The criteria they use is based upon 1974 Bureau of Census estimates of population and data on the number of non-Federal primary care physicians active in patient care in 1974. There have been no updates since. At the time, they found that the mean population ratio in the U.S. was 2,360:1 (42/100,000). The value of 3,500:1 was chosen to indicate shortage because:

1. The value was approximately 1.5 times the mean value for the nation and picked out the lowest quarter of the country's counties.

2. It was assumed that an area with a ratio of 50% worse than the national county average would not be providing adequate care.

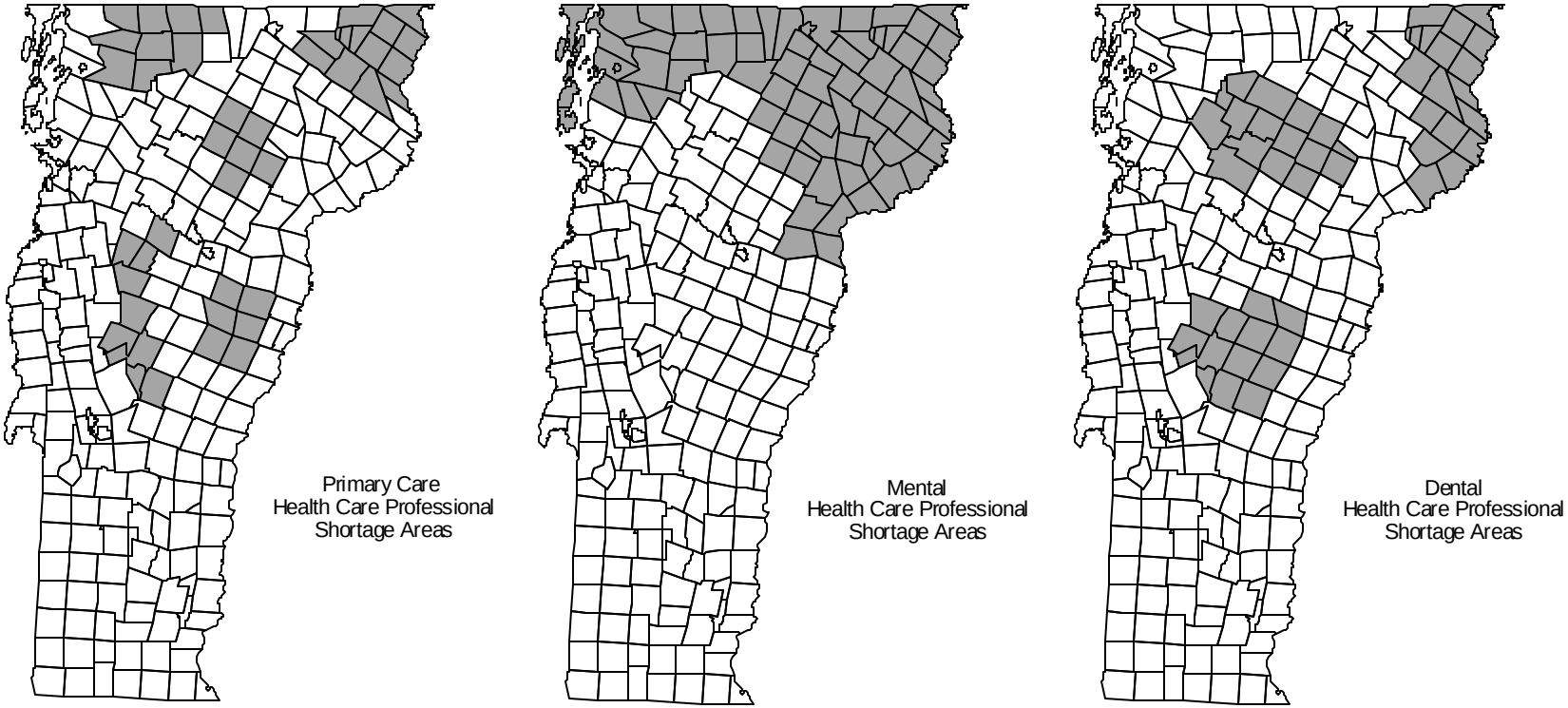
Similar methodology is used to identify areas with a shortage of dental and mental health providers. For a Dental Health Professional Area designation, the population to dentist ration must be 5000:1 or worse. For mental health, the ratio of population to mental health providers must be a) a population- to- core mental health professional ratio greater than or equal to 4,500:1 and a population-to-psychiatrist ratio greater than or equal to 15,000:1; or b) a population-to-core professional ratio greater than or equal to 6,000:1; or c) a population-to-psychiatrist ratio greater than or equal to 20,000:1.

### *5. Safety Net Providers*

Safety net providers in Vermont include two Federally Qualified Health Centers (5 clinic sites), 21 Rural Health Clinics, nine Clinics for the Uninsured (Free Clinics) and more than 45 hospital-owned satellite practices (***Figure 56***). In addition, according to Vermont Department of Health's 1998 survey of physicians, over eighty percent of all private practice physicians in the state accept new patients on Medicaid and/or Medicare, despite their complaints about the reimbursement levels.

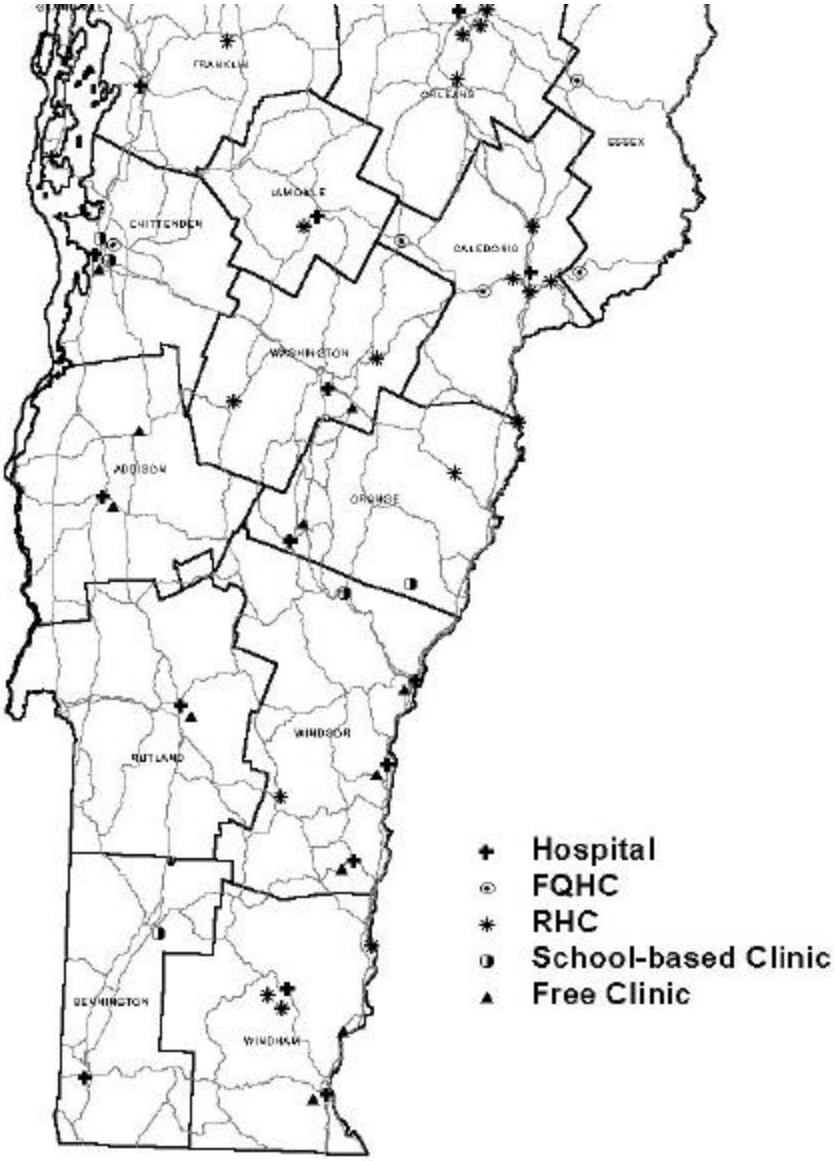
Safety net providers were represented on the HRSA steering committee. Because all serve the uninsured or underinsured now with little restriction, expansion of insurance coverage would generally enhance their revenue. The primary exception would be if there were significant expansion of public programs in the practices that do not receive cost-based reimbursement from Medicaid and Medicare. Substitution of full pay clients with lower pay public programs would be detrimental.

**Figure 55**
**Health Professional Shortage Areas (HPSAs) in Vermont**




Source: Office of Rural Health and Primary Care, Vermont Department of Health, October 2001

**Figure 56**
**Primary Care Sites in Vermont**




Source: Office of Rural Health and Primary Care, Vermont Department of Health, October 2001

## *6. Vermont Hospital Capacity*

In addition to provider capacity, it is equally important to assess whether hospitals in Vermont would also have the capacity to meet consumer demands once universal coverage is achieved. ***Figure 57*** shows that Vermont (283) has a higher rate of beds per 100,000 than New England (255), but a slightly lower rate than the United States (311). Vermont hospitals, responding to changes in hospital utilization have significantly reduced the number of beds for which they maintain staff over the years.

**Figure 57**
**Beds per 100,000: 1998**

| State/Region | Beds per 100,000 |
|---|---|
| **Vermont** | 283 |
| **New England** | 255 |
| **United States** | 311 |

Source: Lewin Group analysis of American Hospital Association (AHA), *Hospital Statistics 2000* data and 1998 U.S. Census Bureau data.

### *7. Utilization of Health Care Services*

This section presents estimates of the utilization increase in health care services with universal coverage and the costs associated with these increases. These estimates are adjusted for age, sex, and health status to account for differences among the insured and uninsured population as well as for differences across state populations. Lewin's analysis begins with an estimate of the distribution of the insured and uninsured population by self-reported health status in ***Figure 58***. A slightly greater percentage of the insured report having either "excellent" or "very good health" status, and a slightly greater percentage of the uninsured report having either "fair" or "poor" health status. Nationally, almost 40 percent of the insured population report having "excellent" health status compared to approximately 36 percent of the uninsured population.

**Figure 58**
**Distribution of Insured and Uninsured People by Self-Reported Health Status: United States**

| Self-Reported Health Status | Insured | Uninsured | Insured Adjusted for Age and Sex |
|---|---|---|---|
| **Excellent** | 39.7% | 35.7% | 40.3% |
| **Very Good** | 31.4% | 27.1% | 31.8% |
| **Good** | 20.4% | 25.7% | 20.1% |
| **Fair** | 6.2% | 8.8% | 5.7% |
| **Poor** | 2.3% | 2.7% | 2.1% |

Source: Lewin Group estimates based on the 1996 Medical Expenditures Panel Survey (MEPS) data.

The insured are typically older than the uninsured. Because health status tends to decline with age, a comparison of insured to uninsured people understates the difference in health status for the two groups. Thus, we adjusted the health status for age differences to estimate an "age and sex adjusted" health status distribution for the insured. Doing so shows an even larger gap between the health status of insured and uninsured people (***Figure 58***).

***Figure 59*** presents estimates of the increase in utilization of health care services if the uninsured become fully insured under universal coverage. These estimates show that the currently insured population utilizes health care services at a higher rate than the uninsured population, with the exception of emergency room visits. However, utilization for the uninsured increases

dramatically once they become insured, with the exception of emergency room visits, which actually decrease from 204 to 182 visits per 1,000.

**Figure 59**
**Health Services Utilization for People Under Age 65 by Insured Status [a/]**

| | | Uninsured Under Current Policy | | |
|---|---|---|---|---|
| | Currently Insured | Current Utilization | Utilization if Become Covered [b/] | Utilization if Health Status Improves [c/] |
| **Physician Visits per 1,000** | 3,650 | 1,705 | 3,432 | 3,513 |
| **Dental Visits per 1,000** | 1,222 | 565 | 1,166 | 1,159 |
| **Hospital Stays per 1,000** | 79 | 68 | 77 | 77 |
| **Outpatient Visits per 1,000** | 484 | 305 | 482 | 494 |
| **Emergency Room Visits per 1,000** | 188 | 204 | 182 | 187 |

a/ Utilization rates per 1,000 people.
b/ Assumes that health services utilization for newly covered people adjusts to the levels reported by insured people with similar age, sex, and health status characteristics.
c/ Assumes that health status of newly covered people adjusts to levels reported by insured people by age and sex.
Source: Lewin Group analysis of the 1996 Medical Expenditures Panel Survey (MEPS) data.

If we also assume that health status improves when the uninsured become insured, utilization of physician services, outpatient visits, and emergency room visits actually increase slightly. Hospital stays remain the same after adjusting for health status and dental visits actually decrease slightly.

### *8. Costs of Covering the Uninsured*

***Figure 60*** presents estimates of the percentage increase in aggregate statewide utilization of health care services (i.e., utilization for both insured and uninsured) if the uninsured become covered. These estimates indicate that utilization of health care services would increase if the uninsured become covered, with the exception of emergency room visits, which actually decrease by 0.9 percent. The most significant increase was for physician and dental visits, 3.7 percent and 4.3 percent respectively.

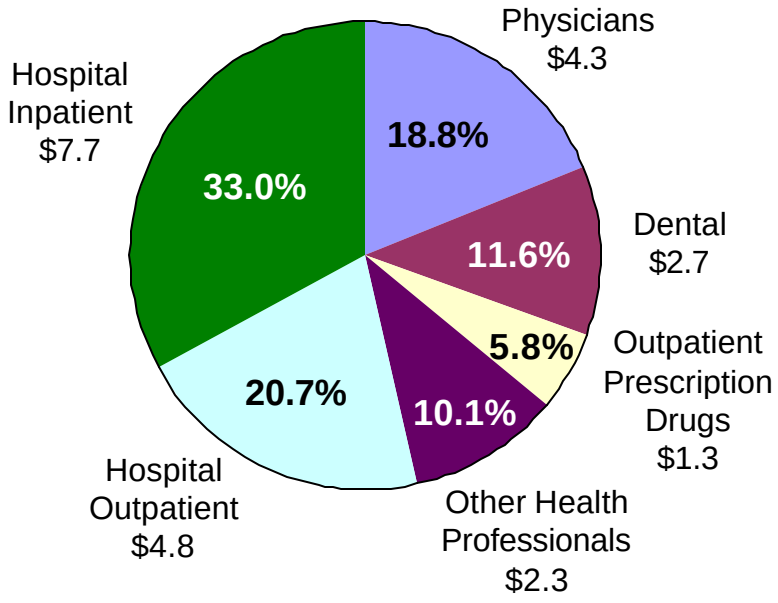
**Figure 60**
**Percentage Increase in Aggregate State-Wide Utilization of Health Care Services if Uninsured Become Covered**

| | Percentage Increase in Utilization |
|---|---|
| **Physician Visits** | 3.7% |
| **Dental Visits** | 4.3% |
| **Hospital Stays** | 0.7% |
| **Outpatient Visits** | 2.6% |
| **Emergency Room Visits** | (0.9%) |

Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM)

***Figure 61*** presents estimates of the increase in health services costs if universal coverage is achieved in 2002. Hospital inpatient services, which account for the largest percentage of costs (33.0 percent), are estimated to increase by $7.7 million in 2002. The smallest estimated increase in costs is for outpatient prescription drugs ($1.3 million). Overall, health care costs are estimated to increase by $23.1 million if universal coverage is achieved in 2002.

**Figure 61**
**Increase in Health Services Costs if Universal Coverage is Achieved in 2002 for Vermont (in millions)**




**Total Increase = $27.6 million**

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

## SECTION FOUR: OPTIONS FOR EXPANDING COVERAGE

One of the primary objectives of the State Planning Grant was to evaluate the cost and coverage impacts of a wide range of options for expanding insurance coverage in Vermont. During the course of the project, Lewin analyzed several general approaches for increasing coverage. These include mechanisms for expanding coverage through public programs and through private insurance.

For each option, Lewin estimated the number of people who would become insured and the cost of subsidies provided under the program. This includes estimates of the cost to the state and costs to the federal government under policies where federal matching funds are available. Also within each of the eight general types of policy options, Lewin examined several variants to show the sensitivity of program costs and coverage impacts to various design parameters.

The purpose of this section is to introduce these policy options and present estimates of their impacts. It also provides a description of the methods and approaches used to perform these analyses. The Lewin presentations on coverage options are presented in ***Appendix H***. A detailed analysis of adopting a single-payer model for Vermont is presented in ***Appendix F***. The analysis is presented in the following sections:

? Methods and Approach;

? Increase Participation Among VHAP-Eligible People;

? Expanding Medicaid Eligibility for Adults;

? Medicaid Buy-In to Employer Coverage for Children;

? Buy-In to VHAP for Employers and Individuals;

? Programs to Assist Families in Purchasing Coverage

? Subsidies to Help Employers Purchase Coverage for Their Workers;

? Create Low-cost Health Insurance Coverage Options;

? A Single-Payer Model for Vermont;

? Comparison of Policy Alternatives; and

? Policy Recommendations of Steering Committee

### A. Methods and Approach

The estimates presented in this report were developed using The Lewin Group Health Benefits Simulation Model (HBSM), which was adapted for use in Vermont. The HBSM is a micro-simulation model of the U.S. health care system. The model is designed to simulate policies

ranging from narrowly defined Medicaid coverage expansions to broad-based reforms such as changes in the tax treatment of health benefits. The model also has been used to simulate the impact of numerous universal coverage proposals such as single-payer plans and employer mandates. For this project, Lewin adapted the model to simulate these impacts for Vermont using primarily data from the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), Vermont Division of Health Care Administration.

The primary database used in the model is the 1996 National Medical Expenditure Panel Survey (MEPS) data developed by the Agency for Healthcare Research and Quality (AHRQ).[31] These data provide information on sources of insurance coverage, health spending and demographic characteristics for a representative sample of households. Lewin adjusted these data to reflect the recent BISHCA survey of Vermont households showing the distribution of people in Vermont by source of insurance coverage and other demographic characteristics.[32] The health expenditure data in the database were also adjusted to reflect estimates of health expenditures in the state as estimated by BISHCA.[33] The model also uses as input a recent survey of employers conducted by the Kaiser Family Foundation and the Health Research and Education Trust (HRET), which provides information on employer characteristics and health plan provisions.[34]

Lewin developed HBSM to provide comparisons of the impact of alternative health reform models on health coverage and expenditures for employers, governments and households. The key to its design is a "base case" scenario depicting the distribution of health services utilization and expenditures across a representative sample of households under current policies for a base year, which in this study is 2001. Lewin also "aged" these data to be representative of the population in the base year (2001) based upon recent economic, demographic and health expenditure trends. The resulting database provides a detailed accounting of the Vermont health care system. These base-case data then serve as the reference point for Lewin's simulations of alternative health reform proposals.

Lewin estimated the impact of various health reform initiatives using a series of methodologies that apply uniformly in all policy simulations. The model first simulates how specified state policy options would affect sources of coverage, health services utilization, and health expenditures by source of payment (***Figure 62***)**.** Mandatory coverage programs such as employer mandates or single-payer models can be simulated based upon the detailed employment and coverage data recorded in the database. The model also simulates enrollment in voluntary programs such as tax credits for employers and employees, based upon multivariate models of

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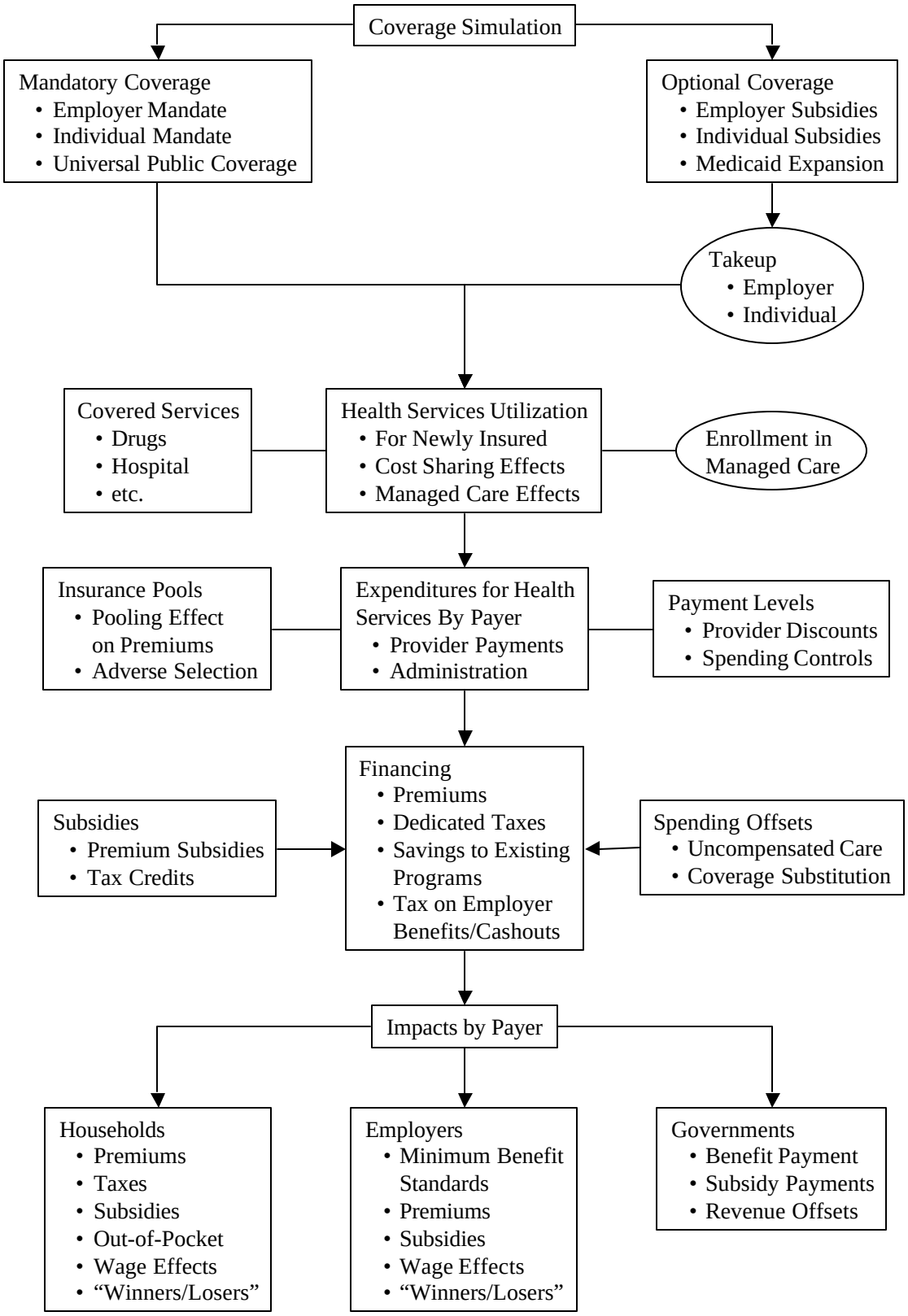
[31] MEPS is sponsored by the Agency for Health Care Policy and Research. For more information about MEPS, see J. Cohen et al. , "The Medical Expenditure Panel Survey: a national health information resource" *Inquiry*. 1996-97 Winter;33(4):373-89.

[32] "Counting What Counts: Health Insurance Coverage in Vermont, First Findings from the 2000 Vermont Family Health Insurance Survey", Vermont Department of Banking, Insurance, Securities and Health Care Administration, Vermont Division of Health Care Administration, July 2001.

[33] "Vermont Health Care Expenditures Analysis, 1999", The Department of Banking, Insurance, Securities and Health Care Administration, Vermont Division of Health Care Administration, August 2001.

[34] L. Levitt, J. Gabel, et al. Employer Health Benefits 1999 Annual Survey. The Henry J. Kaiser Family Foundation and Health Research and Educational Trust. 2000

**Figure 62**
**Flow Diagram of the Health Benefits Simulation Model (HBSM)**



how coverage levels for these groups varies with the cost of coverage (i.e., modeled as the premium minus the tax credit). In addition, the model simulates enrollment in Medicaid or SCHIP expansions based upon a multivariate analysis of historical take-up rates under these programs, including a simulation of the substitution of public for private coverage under these proposals (i.e., "crowd out").

The HBSM is designed to facilitate comparisons of alternative health reform initiatives using uniform data and assumptions. For example, take-up rates for Medicaid and various tax credit/premium voucher policies are simulated using uniform take-up equations and modules. Uniform methods are also used to simulate changes in health services utilization attributed to changes in coverage status and cost-sharing parameters. The model also uses a series of uniform tables for reporting the impacts of these policies on households, employers and governments. This uniform approach assures that the estimates of program impacts for very different policies are based upon consistent assumptions and reporting formats.

Once changes in sources of coverage are modeled, HBSM simulates the amount of covered health spending for each affected individual, given the covered services and cost sharing provisions of the health plan provided under the proposal. This includes simulating the increase in utilization among newly insured people and changes in utilization resulting from the cost sharing provisions of the plan. In general, Lewin assumed that utilization among newly insured people will increase to the level reported by insured people with similar characteristics.

The various steps included as part of the simulation modeling include:

? **Establishing a Baseline:** HBSM is based upon a representative sample of households, which includes information on the economic and demographic characteristics of these individuals as well as their utilization and expenditures for health care. As discussed above, these data were derived from the 1996 Medical Expenditures Panel Survey (MEPS) that is controlled to replicate the distribution of individuals by coverage status and demographic group reported in the recent survey of Vermont households. Lewin also used the Kaiser/HRET survey of employers in simulations of policy scenarios involving employers. In addition, Lewin adjusted these data to show the amount of health spending in the state by type of service and source of payment as estimated by BISHCA.

? **Determining Eligibility:** The HBSM database provides the detailed demographic and economic data required to identify people who would be eligible for public- or private-sector programs designed to expand insurance coverage. The model identifies those who meet the income or work eligibility provisions for any coverage expansion proposals modeled. Eligibility for Medicaid or other income-tested subsidy programs is determined on the basis of family income in each month. The model also identifies people who are potentially affected by programs designed to expand employer coverage such as tax credits and income-tested premium subsidy programs.

? **Modeling Program Participation:** Most of the major health reform proposals developed in recent years would rely upon providing incentives for individuals to obtain coverage rather than mandating coverage. This has required the development of models that estimate the likely response of individuals to various forms of subsidized coverage. Lewin has developed

models of enrollment for the Medicaid/SCHIP program nationally to simulate enrollment among people who become eligible for VHAP under proposed expansions in this program. Lewin has also developed multivariate models of how changes in premiums affect the decision to take-up private insurance coverage.

? **Modeling Employer Responses:** The model also simulates the impact of policies affecting the employer's decision to offer insurance and the resulting impact on employee coverage. An example of one policy option is employer tax credits designed to encourage employers to offer coverage and tax reform proposals that change the relative tax advantages of employer-provided insurance. In these simulations, the model first simulates changes in employer decisions to offer coverage at the firm level using the Kaiser/HRET data and then simulates the corresponding impact on workers who have been assigned to each of the firms in the Vermont database. As discussed above, this often involves compiling data on the workers assigned to each firm such as the average marginal tax rate for workers or the number of employees who are eligible for a particular coverage expansion program.

? **Program Costs and Health Expenditures:** The model simulates the cost of health coverage expansion proposals based upon the coverage provisions of the proposal. For tax credit proposals and premium vouchers, program costs are equal to the amounts of the credits or vouchers for people who participate in the program. Under proposals where benefits for eligible individuals are provided through a public program (e.g., Medicaid), costs are equal to the cost of the health services used by enrollees. These costs are estimated based upon the cost of covered services received by individuals in the household database who are simulated to enroll in the program. This includes expenditures reported in these data during the months in which the individual is simulated to participate in the program, plus an estimated increase in spending for newly insured individuals.

For each option, the model estimates the impact on health expenditures in Vermont by type of service (such as hospitalization and physician visits) as well as the changes in costs for various stakeholder groups. HBSM also provides information on the financial impact of programs to expand coverage for state, federal and local governments. It provides estimates of how these policies may affect employer costs by firm size and industry as well. Finally, it provides estimates of the impact of these reforms on household health spending by income, age and several other population characteristics. The model can also simulate several policy options at the same time.

## B. Increase Participation Among Medicaid/VHAP/Dr. Dynasaur Eligible People

The Vermont household survey data indicates that up to 39 percent of all uninsured people in the state are actually eligible for traditional Medicaid, VHAP, or Dr. Dynasaur. The survey reports that there are 51,390 uninsured people in the state, including 6,191 children and 45,199 adults (***Figure 63)***. About 4,914 children have incomes below 300 percent of the FPL, which is the income eligibility level under the Dr. Dynasaur. In addition, there are about 15,096 adults with incomes below the VHAP income eligibility levels for adults (i.e., 185 percent of FPL for

parents and 150 percent of the FPL for non-custodial adults).[35] This is a total of 20,010 uninsured people who meet the income eligibility levels for the program. Thus, about 39 percent of the uninsured in Vermont are actually eligible but not enrolled in Medicaid/VHAP/Dr. Dynasaur.

**Figure 63**
**People in Vermont by Age, Income as a Percentage of the Federal Poverty Level (FPL) and Coverage Status in 2000**

| | All Ages | | All Children | | All Adults | |
|---|---|---|---|---|---|---|
| | Total | Uninsured | Total | Uninsured | Total | Uninsured |
| **Less than 100% FPL** | 79,580 | 11,104 | 19,905 | 1,018 | 59,675 | 10,086 |
| **100% - 149% FPL** | 62,696 | 8,280 | 17,319 | 1,150 | 45,377 | 7,130 |
| **150% - 185% FPL** | 50,846 | 7,022 | 20,579 | 1,190 | 30,267 | 5,832 |
| **186% - 225% FPL** | 47,357 | 7,354 | 9,098 | 667 | 38,259 | 6,687 |
| **225% - 300% FPL** | 102,544 | 4,118 | 28,237 | 889 | 74,307 | 3,229 |
| **300% FPL or More** | 265,805 | 13,512 | 52,387 | 1,277 | 213,418 | 12,235 |
| **Total** | **608,828** | **51,390** | **147,525** | **6,191** | **461,303** | **45,199** |
| **Percentage Uninsured** | | **8.4%** | | **4.2%** | | **9.8%** |

Source: Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), 2000 Vermont Family Health Insurance survey

However, not all adults who meet the income eligibility requirements are eligible. This is because adults must be uninsured for at least 12 months to qualify (exceptions are permitted for people who involuntarily lose their coverage). The BISHCA survey indicates that about 31 percent of uninsured people in the state have been uninsured less than 12 months which is the length of the waiting period requirement. To account for the fact that many of these individuals would qualify for an exception to the rule it was assumed that 25 percent of income eligible adults do not meet this waiting period requirement. There is no waiting period requirement for children. Using this assumption, Lewin estimates that there are about 20,010 uninsured people in Vermont who are eligible for Medicaid/VHAP/Dr. Dynasaur coverage.

These data indicate that the state could substantially reduce the number of uninsured by increasing enrollment in the existing programs. For example, if the state could sign up about half of those who are eligible but not enrolled in the program, the number of uninsured would be reduced by about 10,000 people (***Figure 64***). This would reduce the percentage of people without health insurance from its current level of 8.4 percent to 6.8 percent. The total cost of covering these people would be $29.3 million, of which the state share would be $10.6 million. This assumes that federal matching funds are available and that the increase is within the budget neutrality requirement of the 1115a waiver.

[35] Estimate reflects the impact of the 12-month waiting period.

**Figure 64**
**Potential Impact of Increasing Medicaid/VHAP/Dr. Dynasaur Enrollment: Assumes Half of Eligible Not Enrolled Population Becomes Covered**

| | Number Enrolled | Reduction in Uninsured | Total Cost | State Share of Cost |
|---|---|---|---|---|
| Children | 2,457 | 2,457 | $2.6 | $0.7 |
| Adults | 7,549 | 7,549 | $26.7 | $9.9 |
| **TOTAL** | **10,006** | **10,006** | **$29.3** | **$10.6** |

Source: Lewin Group estimates.

The state has already implemented a number of initiatives designed to increase enrollment of children (***Figure 65)***. These include media campaigns, outreach through schools and conferences, and presentations to health professionals and various community organizations. The state has streamlined the enrollment process by reducing the length of the application and permitting mail-in applications. Children are also certified for 12 months rather than the 6 months allowed in some other states, which is designed to keep children in the program longer. The state also conducts a number of outreach activities through schools, child-care organizations and employers.

There are other potential changes that could increase enrollment. For example, the state could eliminate the premium requirement for children living above 225 percent of the FPL. The premium for these families ranges between $10 and $25 per family per month depending upon income. The available research indicates that participation is reduced by about one-third in cases where a premium is required, even where the premium is as low as $10 per month. Thus eliminating the premium could result in a substantial increase in enrollment (premium increases are pending).

## C. Expanding Medicaid Eligibility for Adults

The income eligibility levels under the Vermont VHAP program are among the highest in the country. As shown in ***Figure 66,*** Vermont has exercised options available to states to increase eligibility beyond the federal minimum eligibility levels. Aged and disabled people are covered through about 114 percent of the FPL compared with the federal minimum of 76 percent of the FPL (92 percent of the FPL for married couples).[36] Pregnant women are covered through 200 percent of the FPL, and all children are eligible through 300 percent of the FPL.[37]

[36] The income eligibility level for aged and disabled people is equal to 114 percent of the FPL in Chittenden County and 105 percent of the FPL in the rest of the state.

[37] All children are enrolled in the Dr. Dynasaur program. The standard federal matching rate applies to children though 225 percent of the FPL, while the SCHIP enhanced matching rate applies for children between 225 and 300 percent of the FPL.

## Figure 65
## Vermont Covering Kids Project: Overview of Outreach Activities

**Public Awareness**

- Media

  "Got Insurance" Posters
  "Got Insurance" Band-Aid Dispense Magnets
  "Got Insurance" Newsletter Ads
  "Got Insurance" Buttons
  DOH Insurance Cards (all Vermont Schools)
  Dr. Dynasaur Bookmarks
  Governor Dean PSA

- Schools

  School Nurses
  Guidance Counselors
  School Report Card Insert
  First Day of School Activities
  Parent Back-to-School Night

- Conference and Resource Fairs

  VT Home Show and Health Fair
  Dr. Dynasaur Costume

**Presentations, Trainings, Information Dissemination, etc.**

Child Care Providers

Physicians

Hospital Emergency Staff

Non-Profit Providers

Health Fairs

Landlord Associations

Ecumenical Councils

Youth Groups and Organizations

Guardian Ad Litems

Food Distribution Programs

Parent/Child Centers

Community Action Agencies

Refugee Resettlement Programs

Local Businesses (Human Resource Depts.)

**"Gateways" (for screening for health insurance)**

Birth Certificates

Child Care Providers

Physicians (health screening incorporated into periodicity schedule)

School Emergency Cards

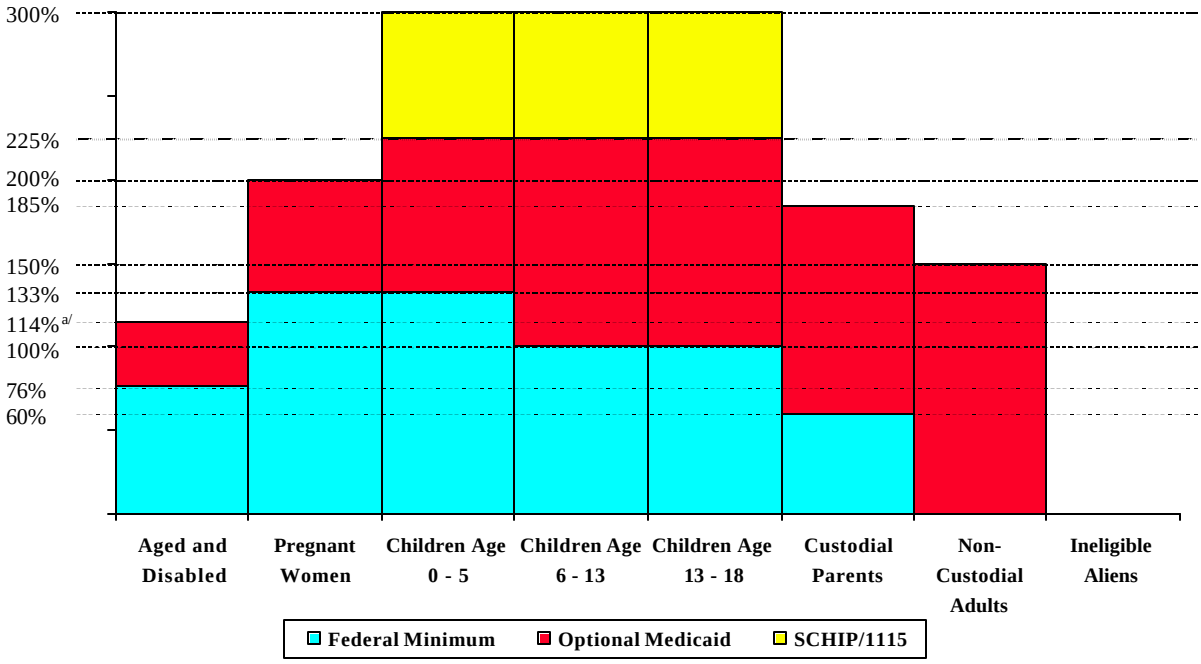
Dept. Of Employment and Training

Hospitals (on-line application process)

Free Clinics

Child, Youth, and Family Support Organizations

**Figure 66**
**Summary of Income Eligibility Levels as a Percentage of the Poverty Level for Medicaid and SCHIP in Vermont**




a/ The income eligibility level for aged and disabled people is equal to 114 percent of the FPL in Chittenden County and 105 percent of the FPL in the rest of the state.
Source: Lewin Group analysis of Vermont Medicaid and SCHIP programs.

The state has also expanded coverage for adults. For example, the state has exercised its option to increase the income eligibility level for custodial parents above the federal minimum (about 60 percent of the FPL in Vermont) to 185 percent of the FPL.[38] The state also covers non-custodial adults through 150 percent of the FPL under an 1115a Medicaid waiver program. There are only six other states with an 1115a waiver to cover non-custodial adults.[39]

Under section 1931 (b) of federal Medicaid law, Vermont has the option to increase the income eligibility level for parents through Medicaid to match the maximum income level at which children are eligible for Dr. Dynasaur (i.e., 300 percent of the FPL). Vermont could use this option to increase the income eligibility level for parents from its current level of 225 percent of the FPL to 300 percent of the FPL. For these newly eligible adults, Vermont would receive

[38] Under federal law, the state's income eligibility level for parents must be at least equal to the income eligibility level for families under the ADFC program (also known as the TANF) income eligibility levels.

[39] There are seven states with an 1115 waiver to cover non-custodial adults including; Vermont, New York, Tennessee, Massachusetts, Oregon, Hawaii, Delaware, and Arizona. In addition, Minnesota and Washington cover non-custodial adults under a state-only program (i.e., no federal matching funds).

federal matching funds at Vermont's standard federal Medicaid matching rate of about 63 percent.[40]

Vermont could also increase income eligibility levels for non-custodial adults, but would not receive federal matching funds. The state receives matching funds for non-custodial adults below 150 percent of the FPL now only because the state obtained a waiver to cover this group. Under the federal waiver process, states are permitted to extend coverage to categorically ineligible groups only if it is implemented as part of an overall program that is "budget neutral". Vermont was able to meet this revenue neutral requirement by also placing a large portion of the states categorically eligible population in managed care programs that were projected to save enough to pay for the costs of covering non-custodial adults through 150 percent of the FPL. Analyses performed by the state indicate little flexibility under the budget neutrality requirement.

In this analysis, Lewin estimated the impact of expanding coverage to adults to various income levels up to 300 percent of the FPL. People between 225 percent and 300 percent of the FPL would also pay a premium on a sliding scale with income similar to that used in Dr. Dynasaur for children in this income range. Lewin estimated coverage and cost impacts under the following Medicaid expansion options:

? Cover custodial parents below 225 percent of the Federal Poverty Level (FPL);

? Cover custodial parents below 300 percent of the FPL;

? Cover non-custodial adults below 185 percent of the FPL;

? Cover non-custodial adults below 225 percent of the FPL;

? Cover non-custodial adults below 300 percent of the FPL;

Using the methods described above, Lewin estimated that about 81,900 adults would meet the income eligibility levels if eligibility were increased to 300 percent of the FPL for all adults (***Figure 67*****).** However, most of these adults already have coverage from some other source and would not qualify due to the waiting period requirement. Based up historical data on enrollment patterns under such public programs, Lewin estimates that about 13,000 of these adults would enroll. In addition, in the course of screening adults for eligibility, Lewin estimates that about 500 children who are currently eligible but not enrolled would become covered. These include children whose parents do not pursue enrollment for their children until they are motivated to apply for themselves or as a family unit.

[40] Under Medicaid, the federal government pays about 63 percent of the program costs under the traditional Medicaid program and about 73 percent of costs under the portion of Dr. Dynasaur program attributed to the State Children's Health Insurance Program (SCHIP).

## Figure 67
## Estimated Coverage and Cost Impacts of Selected Expansions in the Vermont Medicaid/SCHIP Program

| | Newly Eligible People (in thousands) | Newly Enrolled People (in thousands) | Newly Insured Enrollees a/ (in thousands) | Benefits Costs (in millions) | Premium Revenues b/ (in millions) | Net Program Cost (in millions) | State Share of Costs (in millions) |
|---|---|---|---|---|---|---|---|
| **Eligibility Level** | | | | | | | |
| **Below 185% FPL** | | | | | | | |
| **Children** | - - | - - | - - | - - | - - | - - | **- -** |
| **Parents** | - - | - - | - - | - - | - - | - - | **- -** |
| **Other Adults** | 10.4 | 4.5 | 4.3 | $9.5 | - - | $9.5 | **$9.5** |
| **Total** | **10.4** | **4.5** | **4.3** | **$9.5** | **- -** | **$9.5** | **$9.5** |
| **Below 225% FPL** | | | | | | | |
| **Children c/** | - - | 0.5 | 0.5 | $0.3 | - - | $0.3 | **$0.1** |
| **Parents** | 8.8 | 1.5 | 0.5 | $2.8 | - - | $2.8 | **$1.0** |
| **Other Adults** | 20.3 | 6.8 | 5.9 | $14.6 | - - | $14.6 | **$14.6** |
| **Total** | **29.1** | **8.8** | **6.9** | **$17.7** | **- -** | **$17.7** | **$15.7** |
| **Below 300% FPL** | | | | | | | |
| **Children c/** | - - | 0.5 | 0.5 | $0.3 | - - | $0.3 | **$0.1** |
| **Parents** | 36.0 | 4.4 | 1.2 | $8.2 | $3.1 | $5.1 | **$1.9** |
| **Other Adults** | 45.9 | 8.6 | 6.6 | $17.4 | $2.0 | $15.4 | **$15.4** |
| **Total** | **81.9** | **13.5** | **8.3** | **$25.9** | **$5.1** | **$20.8** | **$17.4** |

a/ The number of new enrollees who otherwise would been uninsured.
b/ Lewin assumed that a premium would be required for people above 225 percent of the FPL on a sliding scale with income.
c/ Lewin estimates that there would be a small increase in SCHIP enrollment as newly eligible parents become enrolled. These SCHIP-eligible children who have not enrolled under the current program.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

Overall, about 13,500 people would become enrolled in VHAP. Of these, 8,600 (64 percent) would be non-custodial adults. About 4,400 (32 percent) would be parents. Another 500 (4 percent) would be children who are already eligible for the program. Of the 13,500 people who would enroll, about 8,300 (61 percent) would be people who otherwise would be uninsured. The remaining 5,200 (39 percent) would be people who otherwise would have been covered under a private employer health plan.

Expanding coverage for adults to 300 percent of the FPL would cost about $20.8 million (***Figure 67***). This includes program costs of $25.9 million less premium revenues of about $5.1 million. This is an average cost for this population of about $128 per member per month (PMPM). Of this the state would be responsible for $17.4 million.[41] This reflects the fact that non-custodial adults would not be eligible for a federal match. ***Figure 67*** also shows estimates for Medicaid eligibility expansions to 185 percent and 225 percent of the FPL.

## D. Medicaid Buy-In to Employer Coverage for Children

Under current law, states are permitted to cover Medicaid and SCHIP participants under an employer plan in instances where employer-sponsored coverage is available and cost effective. For example, the Vermont program could screen working VHAP-eligible people for the availability of employer coverage at work. The state would then compare the employee premium contribution required to enroll the family in the employer plan with the expected cost of covering the individual under VHAP. If the employer premium contribution is less than costs under VHAP, the state can pay the employee share of the premium to cover the individual under the employer's plan. This will typically occur in cases where the employer pays at least 50 percent of the premium. However, the state must provide wrap-around coverage to cover all services and cost sharing amounts covered by the VHAP program that are not covered under the employer-sponsored plan.

Several states including Vermont have utilized this approach under Medicaid. However, most states have considered it to be too expensive to administer, particularly in cases where the state must provide wrap-around coverage. These programs have typically been small due to the fact that few Medicaid beneficiaries are working and eligible for employer benefits. This approach has received more attention as income eligibility levels for children have increased to levels where there are more working families. The opportunities for this type of program are strong in Vermont because eligibility levels are sufficiently high that many families will have access to employer-sponsored coverage. The program's impact would be limited by the fact that the number of children covered under SCHIP is small (3,038 in FY02 budget).

For example, the state could screen Dr. Dynasaur-eligible children for the availability of employer-sponsored coverage at a parent's place of employment. The state would then compare the cost of coverage under the program with the employee share of the premium for family coverage under the parent's employer-sponsored plan. If this is less than the cost of coverage

[41] The federal matching rate is about 63 percent for Medicaid recipients and about 73 percent for people covered under the SCHIP program. In Vermont, the enhanced matching rate also applies to children age 6 and older between 100 percent and 133 percent of the FPL.

under Dr. Dynasaur, the state would pay the family share of the premium on the working parent's plan to cover the child under the private employer health plan.

This approach will often have the added bonus of covering the spouse of the worker as well. This would occur in instances where paying the family premium automatically extends coverage to the spouse of the worker. Thus, coverage could be extended to parents who are not eligible for the Medicaid/VHAP/Dr. Dynasaur program as long as there is no additional cost to the program.

Lewin estimated the coverage and cost impacts of adopting this approach for the Dr. Dynasaur eligible populations. These estimates are based upon a study of enrollment and costs under the Vermont Medicaid program, which has been using this approach for nearly 10 years. This study estimated the percentage of the caseload that was potentially eligible for this program and estimates of the savings resulting from this approach under the Vermont program. Based upon these data, Lewin estimates that if implemented in Vermont, about 823 children would qualify, including 355 who would not have enrolled in the absence of the program (includes children and spouses of working parents). Lewin estimates that the state would save about $110,000 under this program (***Figure 68***).

**Figure 68**
**Estimated Impacts of a Children's Buy-In to Parent's Employer Plan**

| | Number Enrolled | Newly Insured | Total Program Costs (in thousands) | State Share (in thousands) |
|---|---|---|---|---|
| **Buy in for Children under Medicaid/VHAP/Dr. Dynasaur** | 823 | 355 | ($391) | ($101) |

Source: Lewin Group estimates based upon experience in other states with program.

## E. Buy-In to VHAP for Employers and Individuals

The VHAP program could be used to provide a lower cost coverage alternative for individuals and employers. For example, individuals without access to employer coverage living below 300 percent of the FPL could be permitted to purchase coverage under the VHAP program by paying a premium. Similarly, small employers could be given the option of purchasing coverage for their employees and dependents through VHAP. The benefits provided under the "buy-in" option would be the same as those provided under the current VHAP program. However, buy-in participants would be required to pay a premium equal to the full cost of their coverage (i.e., average cost per enrollee).

Although participants would be required to pay the full premium for coverage, it is still likely to be lower than the cost of purchasing comparable coverage in the private sector. This is because provider payment levels under the VHAP program are generally substantially lower than payments rates under private plans. As discussed above (in Section Three), payments to physicians and other providers under VHAP are currently up to 40 percent less than private

payer rates.[42] In addition, administrative costs under VHAP are generally lower than in private plans because there are no commission payments to brokers and agents, and there is no allowance for insurer profits.

The lower cost of coverage under the buy-in would make coverage substantially less costly than in the private market resulting in an increase in coverage and a reduction in the number of uninsured. For example, coverage under the VHAP program would be comparable to the coverage provided under the BCBS of Vermont "BlueCare" Point of Service option-A program, with three exceptions: 1) BlueCare does not provide short-term care coverage; 2) BlueCare requires greater co-payments for services than VHAP; and 3) there is a 50 percent copayment for drugs up to a maximum out-of-pocket payment limit of $750 (***Figure 69***). However, after adjusting for these differences, the VHAP buy-in premium would be substantially less than private coverage due to lower administrative costs and lower provider payment levels.

**Figure 69**
**Coinsurance Under VHAP and BlueCare (BCBS) Compared**

| **VHAP Cost Sharing** | |
|---|---|
| **Deductible** | None |
| **Co-Payments** | Nominal |
| **Prescription Drugs** | 50% co-pay with $750 Maximum Out-of-pocket limit |
| **BlueCare Program** | |
| **Deductibles** | |
| With referral | None |
| Without referral | $500 |
| **Co-payments** | |
| Primary care | $10 |
| Other providers (with referral) | $20 |
| Without referral (up to limit or $3,000) | 30% |
| **Prescription Drug Co-pays** | |
| Generics | $10 |
| Preferred | $15 |
| Non-Preferred | $30 |

Lewin estimates that the average premium for single coverage under the BlueCare Option-A product would be $329 per person per month (PMPM) in 2003 (***Figure 70***). This estimate was developed in consultation with representatives of BCBS of Vermont and BISHCA officials for 2001. Lewin projected the premium to 2003 based upon recent trends in spending. This compares with an estimated average cost of $206 PMPM under the VHAP program. About two-thirds of the difference in premiums is attributed to lower provider reimbursement levels under VHAP with lower administrative costs accounting for the remainder of the difference. This premium reduction is likely to attract many individuals and employers to the program.

[42] Legislation was adopted in the FY02 Budget Act that would increase the payment rates to Medicare levels over the next few years. However, the legislature has not yet appropriated the funds required to implement these payment increases.

## Figure 70
## Derivation of Monthly Premium Estimates for VHAP Buy-in in 2003

| | At VHAP Payment Levels | | Increase Payments on VHAP Physician/Other Professionals to Medicare Levels | | With Increase in VHAP Payments for All Medical Services to Medicare Levels | | Medicare Payment Levels with $100/$200 Deductible | | Medicare Payment Levels with $200/$400 Deductible | |
|---|---|---|---|---|---|---|---|---|---|---|
| **BlueCare Point of Service Option - Program A** [a/] | | **$329** | | **$329** | | **$329** | | **$329** | | **$329** |
| **Estimated Administration** [b/] | $57 | | $57 | | $57 | | $57 | | $57 | |
| **Pure Premium (i.e., benefits, costs)** | $272 | | $272 | | $272 | | $272 | | $272 | |
| **Change in Administrative Cost** | | **-$44** | | **-$44** | | **-$44** | | **-$38** | | **-$38** |
| **BC/BS Administration** | $57 | | $57 | | $57 | | $57 | | $57 | |
| **VHAP Administration** [c/] | $13 | | $13 | | $13 | | $19 | | $19 | |
| **Change in Pure Premium** | | **-$79** | | **-$48** | | **-$39** | | **-$65** | | **-$76** |
| **BC/BS Pure Premium** | $272 | | $272 | | $272 | | $272 | | $272 | |
| **Payment Level Reductions** | | | | | | | | | | |
| **Hospital** [d/] | -$35 | | -$35 | | -$26 | | -$26 | | -$26 | |
| **Physician/Other Providers** [e/] | -$52 | | -$21 | | -$21 | | -$21 | | -$21 | |
| **Prescription Drug Rebate** [f/] | -$3 | | -$3 | | -$3 | | -$3 | | -$3 | |
| **Change in Copayment Required** | $11 | | $11 | | $11 | | -$15 | | -$26 | |
| **VHAP Buy-in Premium in 2001** | | **$206** | | **$237** | | **$245** | | **$226** | | **$216** |
| **Administrative Cost** | $13 | | $13 | | $13 | | $19 | | $19 | |
| **Pure Premium** | $193 | | $224 | | $232 | | $207 | | $197 | |

a/ BlueCare option program A, Point of Service: $10 primary care co-pay; $20 other office visits; no inpatient or outpatient surgery deductible; prescription drug co-payments: $10 generics; $15 preferred, $30 non-preferred. Premium for 2001 is $298, which Lewin indexed to 2003

b/ Assumes that administrative costs (including marketing and brokers fees) are equal to about 17.5 percent of benefits costs for groups with 25 or fewer workers.

c/ VHAP administrative costs are equal to about 7 percent of benefits costs which comes to about $12 per month for adults currently enrolled under VHAP.

d/ Lewin estimates that hospital payments under the VHAP program are about 32 percent less than commercial payment rates and about 8 percent less than Medicare payment rates.

e/ Lewin assumed that physician payment levels are about 50 percent less than commercial payment levels based upon payment level data indicating that: Medicaid physician payment levels in Vermont are 31 percent less than Medicare payment levels; and national data indicating that Medicare physician payment levels are about 20 percent less than commercial rates. See: Stephan Norton, "Recent Trends in Medicaid Physician Fees, 1993-1998", The Urban Institute.

f/ Assumes a net savings of 10 percent under Medicaid prescription drug rebate program.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Under recent legislation, the state's objective is to increase payment levels to Medicare levels over the next few years. This will increase the VHAP premium, and thereby reduce the number of people who would be induced to enroll. For example, if these payment increases were to be fully implemented in 2003, the VHAP premium would increase to $245. However, the VHAP premium would continue to be less than the BlueCare Option-A premium because Medicare payment amounts are still up to 20 percent less than private payments for comparable services. The VHAP premium also could be reduced by including a small deductible. For example, the VHAP premium could be reduced to $226 PMPM by requiring a $100 deductible ($200 per family).

Enrollment would also be determined by the eligibility criteria used. For example, in the first scenario, it is assumed that eligibility would be limited to people living below 300 percent of the FPL that have been uninsured for at least 12 months (***Figure 71***). Employer groups with 25 or fewer workers also would be permitted to enroll under three conditions including: 1) The firm must not have offered insurance in the past 12 months; 2) the employer must pay half of the premium; and 3) 75 percent of workers must enroll. In this scenario, it is assumed that the buy-in would use Medicare payment levels and have a $100 deductible ($200 family), which is estimated to cost $226 PMPM.

Under this scenario (i.e., scenario #1 in ***Figure 71***), it is estimated that about 8,200 people would become enrolled under the program. These include about 3,100 people purchasing coverage as an individual and about 6,700 workers and dependents who would be enrolled through a participating employer. Of the 8,200 people who would enroll, about 6,900 would be people who would have been uninsured in the absence of the program. The remaining 1,300 would be workers and dependents in participating firms that otherwise would have purchased non-group coverage in the individual market.

By design, the buy-in program would be self-financing. This is because the premium for the program is set equal to average costs per enrollee under the program. Total premium payments under this scenario would be $22.2 million in 2003, which would be roughly equal to program costs. However, enrollment is expected to grow gradually over time as eligible people learn about the program.

The buy-in could be extended to people at higher income levels as well. Scenario # 1 targets uninsured people living below 300 percent of the FPL, because these individuals are perceived to be in the greatest need of assistance. However, the premiums for people attempting to purchase coverage in the individual market are often unaffordable to people above this income eligibility level as well. Therefore, the state could eliminate the income eligibility limit from the buy-in to open eligibility to others as well. Doing so would increase enrollment to 9,400 people, of whom 8,100 would be newly insured (i.e., scenario # 2 in ***Figure 71***).

## Figure 71
## Buy-in Enrollment Under Alternative Eligibility Criteria

| | Scenario # 1 | Scenario # 2 | Scenario # 3 | Scenario #4 |
|---|---|---|---|---|
| **Eligibility for Individuals** | ? Incomes Below 300% of FPL<br>? Uninsured 12 months unless job change or involuntary loss of coverage | ? No income limit<br>? Uninsured 12 months unless job change or involuntary loss of coverage | ? No income limit<br>? No waiting period | ? No income limit<br>? No waiting period |
| **Employer Eligibility** | ? 25 or fewer workers<br>? Have not insured in 12 months<br>? Employer pays half of premium<br>? 75% of workers enroll | ? 25 or fewer workers<br>? Have not insured in 12 months<br>? Employer pays half of premium<br>? 75% of workers enroll | ? 25 or fewer workers<br>? Have not insured in 12 months<br>? Employer pays half of premium<br>? 75% of workers enroll | ? 25 or fewer workers<br>? No waiting period<br>? No employer payment requirement<br>? 75% of workers enroll |
| **Program Enrollment and Cost Share** [a/] | | | | |
| **Enrollment** | 8,191 | 9,379 | 11,995 | 31,694 |
| **Newly Insured** | 6,948 | 8,135 | 8,135 | 8,135 |
| **Premium Receipts (in millions)** | $22.2 | $25.4 | $32.5 | $85.9 |

a/ Assumes a policy with VHAP covered services at Medicare payment levels and a $100/$200 deductible. The monthly premium would be $226 compared to about $329 for similar private coverage. Premium payments are assumed to be equal to program expenses.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Under the first two scenarios, eligibility for both individuals and employers is restricted to only those who have been uninsured for at least 12 months. This is to prevent individuals and employers from discontinuing their current private insurance policy to become covered under the lower cost VHAP buy-in program. However, the state could open enrollment to all individuals and employers by eliminating the 12-month waiting period. If the waiting period were eliminated for both individuals and employers, enrollment would increase to 31,694 (i.e., scenario # 4). All of this increase in enrollment would be for people who drop their private coverage to enroll in the program. Additional detail on Lewin estimates under alternative benefits packages is presented in ***Figure 72.***

**Figure 72**
**Enrollment and Costs under a Buy-in for Employers and Individuals in 2003 under Alternative Eligibility Scenarios** [a/]

| | Newly Enrolled People | Newly Insured People | Benefits Costs (in millions) | Premium Revenues [b/] (in millions) | Net Program Cost (in millions) |
|---|---|---|---|---|---|
| **Scenario #1: People Below 300 percent FPL and 12-month Waiting Period** | | | | | |
| **Employer Groups Only** | 6,654 | 5,409 | $18.0 | $18.0 | $0.0 |
| **Individuals Only** | 3,061 | 3,061 | $8.3 | $8.3 | $0.0 |
| **Both Employer Groups and Individuals** | 8,191 | 6,948 | $22.2 | $22.2 | $0.0 |
| **Scenario #2: No Income Limit and 12-month Waiting Period** | | | | | |
| **Employer Groups Only** | 6,654 | 5,409 | $18.0 | $18.0 | $0.0 |
| **Individuals Only** | 4,512 | 4,512 | $12.2 | $12.2 | $0.0 |
| **Both Employer Groups and Individuals** | 9,379 | 8,135 | $25.4 | $25.4 | $0.0 |
| **Scenario #3: No Income Limit and No Waiting Period for Individuals** | | | | | |
| **Employer Groups Only** | 6,654 | 5,409 | $18.0 | $18.0 | $0.0 |
| **Individuals Only** | 7,128 | 4,512 | $19.3 | $19.3 | $0.0 |
| **Both Employer Groups and Individuals** | 11,995 | 8,135 | $32.5 | $32.5 | $0.0 |
| **Scenario #4: No Income Limit and No Waiting Period for Individuals and Employers** | | | | | |
| **Employer Groups Only** | 26,353 | 5,409 | $71.5 | $71.5 | $0.0 |
| **Individuals Only** | 7,128 | 4,512 | $19.3 | $19.3 | $0.0 |
| **Both Employer Groups and Individuals** | 31,694 | 8,135 | $85.9 | $85.9 | $0.0 |

a/ Assumes full phase in of enrollment in 2003. Assumes an increase in VHAP provider payments to Medicare levels with a $100 deductible ($200 family). The premium would be $226 in 2003. Comparable coverage under BlueCare Program A would cost about $329 per month in 2003.
b/ Assumes premiums are adjusted to equal total program costs.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

## F. Programs to Assist Families in Purchasing Private Coverage

Congress has been considering proposals that would provide assistance to individuals purchasing coverage in the non-group market. Under current law, the amount spent by employers to provide

health benefits is not taxable to the employee even though this is a form of income to the worker. This is a substantial tax subsidy to those receiving coverage from their employer, which equals an average of about $2,000 per worker family.[43] However, individuals who do not have access to employer-sponsored health insurance who must purchase non-group coverage on their own receive no tax benefits.

Some consider this to be a substantial inequity in the tax code. In addition, those without employer-provided health insurance must seek coverage in the non-group market where premiums are typically higher than in the group market.

There are several federal proposals that would provide a tax credit to people purchasing non-group coverage. The tax credit is designed to both encourage these individuals to purchase coverage, and to promote equitable tax policy. To illustrate the impact of such a program, Lewin analyzed an illustrative tax credit typical of those being considered by Congress and the executive branch in the summer of 2001. The tax credit would be available to people purchasing non-group coverage and who do not have access to employer-provided coverage. The credit would be limited to people with incomes below 300 percent of the FPL.

In this illustration, the tax credit would equal specified dollar amounts, such as $1,000 for single individuals and $2,000 for families. The credit would be capped at the amount actually spent on health insurance by the taxpayer. However, the credit would be "refundable", which means the amount of the credit can exceed the amount owed in taxes during a year. This assures that people with too little income to be required to pay income taxes could receive the full amount of the credit. In addition, it is assumed that the tax credit is phased out on a sliding scale with income for people with incomes between 200 percent and 300 percent of the FPL. Lewin analyzed three credit amount scenarios including:

? Credit amount of: $750 for individuals, and $1,500 for families;

? Credit amount of: $1,000 for individuals, and $2,000 for families;

? Credit amount of: $1,250 for individuals, and $2,500 for families.

Lewin estimates that there would be about 47,000 people in Vermont families that qualify for the credit (***Figure 73***)**.** These include people without access to employer-sponsored health insurance who are living below 300 percent of the FPL. Of these, about 26,400 are currently purchasing non-group coverage and about 20,600 people are currently uninsured. In this analysis, it is assumed that all eligible people who are currently purchasing non-group coverage (26,400) would receive the credit. It is also estimated that up to about 7,700 of the 20,260 eligible uninsured people would be induced to purchase coverage with the help of the credit. Thus, the impact of offering a $1,000 tax credit to individuals and a $2,000 tax credit to families would be a reduction of the number of uninsured in the state by about 7,700 people.

[43] John Sheils et. Al. "Health Insurance and Taxes: The Impact of Proposed Changes in Current Federal Policy", (report to the National Coalition on Health Care (NCHC)), October 18, 1999.

**Figure 73**
**Cost and Coverage Impacts of a Tax Credit for Individuals Purchasing Non-group Coverage**

| | Eligible | Enroll | Newly Covered | Total Cost (in millions) | Cost per Enrollee | Cost per Newly Insured |
|---|---|---|---|---|---|---|
| **$750/$1,500** | | | | | | |
| **Currently Insured** | 26,400 | 22,700 | - - | $13.4 | $595 | |
| **Uninsured** | 20,600 | 6,624 | 6,624 | $3.0 | $658 | |
| **Total** | **47,000** | **29,324** | **6,624** | **$16.4** | **$596** | **$3,417** |
| **$1,000/$2,000** | | | | | | |
| **Currently Insured** | 26,400 | 22,700 | - - | $17.8 | $784 | |
| **Uninsured** | 20,600 | 7,728 | 7,728 | $4.8 | $865 | |
| **Total** | **47,000** | **30,428** | **7,728** | **$22.6** | **$797** | **$4,036** |
| **$1,250/$2,500** | | | | | | |
| **Currently Insured** | 26,400 | 22,700 | - - | $20.9 | $921 | |
| **Uninsured** | 20,600 | 9,522 | 9,522 | $7.1 | $1,029 | |
| **Total** | **47,000** | **32,222** | **9,522** | **$28.0** | **$943** | **$4,058** |

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The number of uninsured people who would become covered will vary with the amount of the credit. For example, with a credit amount of $750 for individuals and $1,500 for families, about 6,600 uninsured people would purchase coverage. When the credit is increased to $1,250 for individuals and $2,500 for families, about 9,500 uninsured people would become covered.

It is important to note that most of the tax credit dollars would go to people who already have coverage. For example, under the $1,000/$2,000 tax credit scenario, total tax credit payments would be $22.6 million, of which, $17.8 million would go to people who are already purchasing coverage under current tax law.

## G. Subsidies to Help Employers Purchase Coverage for Their Workers

An alternative approach to expanding coverage would be to provide subsidies directly to employers to help them provide coverage to their workers. This could be accomplished through a refundable tax credit to employers who are not now providing coverage. Existing proposals for an employer tax credit would set the amount of the tax credit equal to a percentage of the employer's expenditures for employee health benefits (e.g., 25 to 40 percent).[44]

To illustrate the potential impact of this approach, Lewin estimated the coverage and cost impacts of an employer tax credit for employee health coverage that is targeted towards small employers with low-wage workers. Eligibility would be restricted to: (1) firms that have not

[44] John F. Sheils, "Health Coverage 2000: Cost and Coverage Analysis of Eight Proposals to Expand Health Insurance Coverage" (report to the Robert Wood Johnson Foundation (RWJF)), September 2000.

provided coverage for at least 12 months; and (2) firms with an average payroll below the average for small firms in the state. These firms would receive these tax credits for a period of three to five years as long as the firm continues to meet the firm size and average payroll eligibility criteria. (The dollar amount of the credit could also be phased-out with percentage reductions each year over the three to five year period.)

In the first scenario, it is assumed that the credit is limited to only firms with 10 or fewer workers. The amount of the credit is assumed to be equal to 25 percent of the employer's expenditures for health benefits. Lewin also estimated the impact of alternative scenarios of eligibility by firm size and tax credit amounts including:

? Firms with 10 or fewer workers - 25 percent credit;

? Firms with 10 or fewer workers - 40 percent credit;

? Firms with 25 or fewer workers - 25 percent credit;

? Firms with 25 or fewer workers - 40 percent credit.

Lewin estimates that there are about 12,700 workers and dependents in firms with 10 or fewer workers in Vermont that would be eligible for the credit (***Figure 74***). These include firms with under 10 workers who have not offered insurance for 12 or more months that also have an average payroll per worker (i.e., full-time equivalent worker) that is less than the average for firms of this size. Of these 12,700 people, about 5,500 are currently uninsured, while about 7,200 already have insurance from some other source (i.e., on-group coverage, dependent of working spouse with employer coverage, etc.).

Assuming the credit is equal to 25 percent of employer costs, it is estimated that about 4,600 workers and dependents would be in firms that are induced to obtain coverage. Of these, 2,500 would be people who otherwise would be uninsured. The total cost of the credit to the state would be $1.9 million.

The state could increase the number of firms that are induced to offer coverage by increasing the credit amount. For example, increasing the amount of the credit to 40 percent of the employer's health benefits costs would increase the number of uninsured people who become covered to about 3,400 people at a total cost of about $4.1 million. In addition, extending the 40 percent tax credit to all firms with under 25 workers (i.e., who meet the average salary requirement) would cover about 4,400 people who otherwise would be uninsured at a cost of $5.0 million (***Figure 74***).

## H. Create Low-cost Health Insurance Coverage Options

The state could also expand coverage by subsidizing the cost of a low-cost health insurance product for employers who currently do not provide coverage. In this analysis, Lewin examined the potential impact of creating in Vermont a program modeled on the "Healthy New York" program recently implemented in New York State. This program permits lower income

**Figure 74**
**Cost and Coverage Impacts of Alternative Tax Credits for Small Employers with Low-wage Workers**

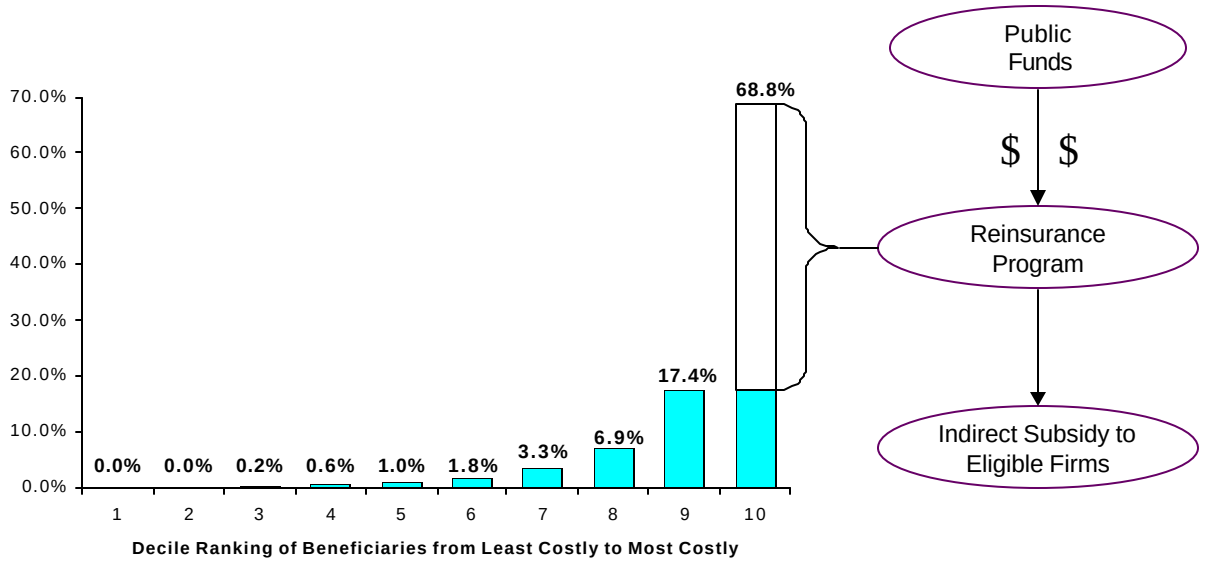
| | Eligible | Enroll | Newly Covered | Total Cost (in millions) | Cost per Enrollee | Cost per Newly Insured |
|---|---|---|---|---|---|---|
| **Under 10 Workers** | | | | | | |
| **25 percent Credit** | | | | | | |
| **Currently Insured** | 7,200 | 2,100 | - - | $1.0 | $483 | |
| **Uninsured** | 5,500 | 2,484 | 2,484 | $0.9 | $494 | |
| **Total** | **12,700** | **4,584** | **2,484** | **$1.9** | **$487** | **$1,045** |
| **40 percent Credit** | | | | | | |
| **Currently Insured** | 7,200 | 2,800 | - - | $2.1 | $790 | |
| **Uninsured** | 5,500 | 3,450 | 3,450 | $2.0 | $810 | |
| **Total** | **12,700** | **6,250** | **3,450** | **$4.1** | **$799** | **$1,712** |
| **Under 25 Workers** | | | | | | |
| **25 percent Credit** | | | | | | |
| **Currently Insured** | 9,300 | 2,700 | - - | $1.2 | $451 | |
| **Uninsured** | 7,200 | 3,312 | 3,312 | $1.1 | $463 | |
| **Total** | **16,500** | **6,012** | **3,312** | **$2.3** | **$457** | **$966** |
| **40 percent Credit** | | | | | | |
| **Currently Insured** | 9,300 | 3,500 | - - | $2.6 | $742 | |
| **Uninsured** | 7,200 | 4,416 | 4,416 | $2.4 | $761 | |
| **Total** | **16,500** | **7,916** | **4,416** | **$5.0** | **$751** | **$1,588** |

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

individuals and employers with lower-wage workers to purchase a private health plan that does not include mandated benefits. The state also effectively subsidizes premiums for eligible employers and individuals in these plans through a modified reinsurance system.

The state subsidy is provided through a reinsurance mechanism that pays a substantial percentage of health benefits costs for high-cost cases among the eligible individuals and employers who purchase such a policy. As shown in ***Figure 75,*** about 70 percent of all costs under a typical health plan are associated with just 10 percent of the covered population. This program subsidizes the cost of coverage for many of these high-cost cases, resulting in lower premiums. Under the Healthy New York program, the state reinsurance program pays 90 percent of costs in excess of $30,000 for each person covered under these plans up to a maximum covered amount of $100,000 per member. The cost of this reinsurance is paid through trust funds established for this purpose using New York tobacco settlement receipts.

**Figure 75**
**Subsidized Insurance for Small Groups Through State-funded Reinsurance**




Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

In New York, it is estimated that premiums under the program will be reduced by about 15 to 20 percent. About half of this amount is attributed to the elimination of mandated benefits, with the other half attributed to the reinsurance subsidy. This reduction in costs is designed to increase the number of employers and individuals with insurance. The program, which was implemented in January 2001, currently has about 3,000 members.

In this analysis, Lewin estimated the impact of adopting a similar program in Vermont using the eligibility criteria used in the Healthy New York program. Self-employed people and other individuals would be eligible if they have been uninsured for 12 or more months and their income is less than 250 percent of the FPL. Eligibility for employers is limited to firms meeting the following criteria:

? Firms with 50 or fewer workers;

? At least half of employees enroll in the plan;

? Have not offered coverage in 12 or more months;

? Less than 30 percent of employees are earning over $30,000; and

? The employer pays half of the premium.

This program would have less of an impact on premiums in Vermont than it will in New York because Vermont has fewer mandated benefits than New York. Thus, only the reinsurance subsidy would have a significant impact on premiums in Vermont. For purposes of developing

estimates for Vermont, Lewin assumed that the program would reduce premiums for participating firms and individuals by about 15 percent.

Lewin estimates that in response to these premium reductions, about 4,000 people would take coverage under these health plans. This includes both individuals and people in firms that are induced to purchase this subsidized coverage (***Figure 76***). Of these, nearly all would be people who otherwise would have been uninsured. The total cost to the state of the reinsurance program would be $860,000.

**Figure 76**
**Low-cost Coverage Options for Non-insuring Firms with Less than 25 Workers**

| | Number Enrolled | Newly Insured | State Cost (in thousands) |
|---|---|---|---|
| **Three-year Exemption from Mandatory Benefits Only** | 1,350 | 1,350 | - - |
| **State-funded Reinsurance Only** | 2,700 | 2,700 | $573 |
| **Mandatory Benefits Exemption with State-funded Reinsurance** | 4,050 | 4,050 | $860 |

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

## I. A Single-Payer Model for Vermont

As part of the State Planning Grant Program, Lewin estimated the impact of a single-payer program in which all state residents are covered under a single public program funded primarily with an employer payroll tax. Lewin estimated the financial impact of a single-payer program on various payers for health care including state, local, and federal governments. It is also estimated the financial impact of the proposal on employers by industry and firm size. In addition, estimates of the impact of the plan on household health spending by age, income level, and other characteristics are presented.

### *1. The Single-Payer Proposal*

The single-payer model is a system where all individuals in the state are covered under a single uniform health plan that is administered and funded by the state. The new single-payer system would replace all current public-sector insurance systems including: Medicare, Medicaid, CHAMPUS and the Federal Employees Health Benefits Plan (FEHBP). It would also replace private health insurance plans in the state. The program would be financed with current government health care funding for discontinued programs and new taxes on employer payroll.

The single-payer benefits package assumed in this analysis is modeled on the benefits typically provided under employer health plans. The program would cover medically necessary inpatient hospital care, physician services (including preventive care), hospital outpatient care, prescription drugs, lab tests, and mental health services (including substance abuse and tobacco cessation). Chiropractic services would be covered when referred by a physician. The program

would cover preventive dental care and vision exams, but it would not cover orthodontia, private rooms, or eyeglasses.

To discourage over-use of services, there would be a $10.00 copayment for ambulatory care services. There would be no deductible. Also, the program would use a primary care provider referral (i.e., gatekeeper) model where patients face increased copayments for visits to specialists without referral. Benefits that are currently provided to Medicaid eligible people that are not covered under the single-payer model would be continued for low-income people who qualify for Medicaid under current eligibility rules.

### *2. Health Spending Under The Single-Payer Program*

The Lewin Group estimated that total health spending for Vermont residents under the current system would be $2.2 billion in 2001. This includes spending for all health care services including benefits payments and insurer administration. The analysis indicated that the single-payer program would achieve universal coverage while actually reducing total health spending by about $118.1 million in 2001 (***Figure 77***). The primary reason for this savings reduction is that the single-payer model substantially reduces the cost of administering health insurance coverage, resulting in savings that can be used to pay for the care that would be provided to people who are currently going without coverage.

Lewin estimates that under current trends, about 51,390 Vermont residents would be without health insurance in 2001. It is estimated that their use of health services would increase by $23.1 million if they were to become covered under the benefits package described above. Also, utilization would increase among currently insured people who currently do not have coverage for certain services such as prescription drugs or preventive dental care by about $39.8 million. Thus, the total increase in utilization of heath services among the uninsured and the under-insured people would be $62.9 million in 2001.

In addition, there would be a net increase in spending of about $2.8 million due to changes in the use of managed care under the program. Lewin also assumed that the government plan would receive higher prescription drug rebates similar to the current rebates received under the State's Medicaid program. These rebates are estimated to be about $30.2 million in 2001.

The cost of these increases in utilization for uninsured and under-insured people would be more than offset by reduced administrative costs under the program. The single-payer system replaces the current system of multiple public and private insurers with a single source of payment for all covered services. This eliminates the complexity of both diverse insurer rules and patient billing for unreimbursed amounts. The single-payer system also replaces hospital billing for individual patients with annual operating budgets, which effectively eliminates claims filing functions for Vermont hospitals. (Claims filing would continue for out-of-state patients.)

**Figure 77**
**Changes in Health Spending in Vermont under a Single-Payer Program in 2001**
**(in millions) [a/]**

| | | Changes in Spending |
|---|---|---|
| **Changes in Health Services Utilization** | | |
| Increase in Utilization Due to Expanded Coverage | | $62.9 |
| Utilization Increase for Previously Uninsured | $23.1 | |
| Expanded Coverage for Those Already Insured | $39.8 | |
| **Change in Administrative Costs** | | |
| Net Change in Administrative Costs | | ($153.6) |
| Insurer Administration (Includes Administration for Newly Insured) | ($106.5) | |
| Physician Administrative Savings | ($19.8) | |
| Hospital Administrative Savings | ($27.3) | |
| **Managed Care Adjustment** | | |
| Managed Care Adjustment [b/] | | $2.8 |
| **Prescription Drug Rebate** | | |
| Prescription Drug Rebate [b/] | | ($30.2) |
| **Net Change in Health Spending** | | |
| Net Change in Health Spending | | ($118.1) |

a/ Includes all people in the state including those with public and private coverage.
b/ Assumes an increase in utilization for people currently covered under HMO plans and an adjustment for higher prescription drug rebates under the government plan.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM)

The single-payer approach would also substantially reduce claims-filing costs for physicians by standardizing the means of reimbursement through a single-payer and by providing full reimbursement through a single source using a standardized electronic claims-filling process. Standardization of coverage would also reduce physician costs related to adjudication of claims and negotiation of selective-contracting arrangements. Total savings to providers would be about $47.1 million. Lewin assumed that provider payments are reduced by this amount so that these savings accrue to payers.

The single-payer program would extend large-group economies of scale for administration of insurance throughout the health care system by covering all individuals under a single insurance mechanism. This would eliminate the costs associated with underwriting, transition in coverage, and maintaining the linkage between employers and insurers. Overall, statewide insurer administrative costs would be reduced from $173 million under current policy to $67 million under the single-payer model for a net savings of about $106.5 million in 2001.

### *3. Impact on Employers*

Health coverage for workers and their dependents under the single-payer model would be financed with a payroll tax, two-thirds of which would be paid by the employer with the rest paid

by the worker. There would be no premiums for the benefits provided under the standard benefits package. Lewin estimates that the payroll tax rates required to fully fund benefits for workers and dependents under the single-payer model would be 5.8 percent for employers and 2.9 percent for employees.

Under these tax rates, total employer health spending in Vermont would increase by $123.2 million in 2001 (***Figure 78***). This includes $119.6 million in payments by firms that currently do not offer coverage. Employer health spending for firms that currently offer health insurance to their workers would increase by about $3.6 million. Currently insuring firms would realize savings attributed to reduced spending for retirees as Medicare beneficiaries are shifted from their current Medicare benefits plan to the more comprehensive benefits package provided under the single-payer model. Employer costs would increase by an average of $1,452 per worker for workers in firms that do not now offer coverage while costs for firms that currently offer coverage would increase an average of only $20 per worker.

**Figure 78**
**Change in Private Employer Costs Under the Single-Payer Model in Vermont in 2001**

| | Change In Health Spending (in millions) | Change in Health Spending Per Worker |
|---|---|---|
| **Before Wage Effects** | | |
| **Firms That Now Offer Insurance** | $3.6 | $20 |
| **Firms That Do Not Now Offer Insurance** | $119.6 | $1,452 |
| **All Firms** | **$123.2** | **$479** |
| **After Wage Effects[a/]** | | |
| **Firms That Now Offer Insurance** | ($30.1) | ($172) |
| **Firms That Do Not Now Offer Insurance** | $0.0 | $0.0 |
| **All Firms** | **($30.1)** | **($117)** |

a/ Employers are assumed to pass-on the savings and/or increases in cost under the single-payer plan to workers in the form of changes in wages as labor markets adjust to these changes in employee compensation.
Source: Lewin Group Estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

However, economic theory and research indicates that over time increases in employer costs for health and other benefits are typically passed on to workers in the form of reduced wage growth. Thus, it is assumed that over the long-term, all of the changes in employer costs for workers under the single-payer plan will be passed on to workers in their wages as labor markets adjust to reflect changes in total employee compensation costs under health reform. Employers are expected to retain any savings in benefits costs for retirees. This is because these savings are attributed to compensation packages for prior workers, which does not affect the labor market for

current workers. Overall, private employers would save about $30.1 million in retiree costs under the single-payer model.

### *4. Household Impacts*

Under a single-payer program, Vermont residents would no longer pay health insurance premiums and would face only $10.00 co-payments for health services. Instead, households would pay taxes on their earnings. In addition, household incomes would be affected by wage adjustments resulting from increased employer spending for health care (i.e., the employer payroll tax). These changes in the way in which care is financed would substantially alter the distribution of health care costs across households of various age and income groups.

Lewin estimates that household health spending would decline by $122.3 million under the single-payer program. This includes the elimination of household premium payments for private health insurance ($321.8 million); and reduced household out-of-pocket payments for health services ($218.8 million). These savings would be offset by increased tax payments of $307 million. In addition, Lewin estimates a loss of wages to households (after tax offsets) of about $111.3 million as employers pass-on the increased cost of complying with the payroll tax to workers in the form of reduced wages.

Overall, Lewin estimates that households would see health spending decrease by an average of about $441 per family under the single-payer model in 2001 (***Figure 79***) In general, the single-payer plan would tend to reduce health care costs for lower- and middle-income families. For example, families with under $75,000 in annual income would, on average, see savings. However, health spending for families with $150,000 or more in income would increase by about $4,490 per family. This reflects the fact that the program shifts Vermont residents away from a premium-financed system, to a tax-financed system where total health spending would be in proportion to family earnings.

Savings under the single-payer plan would tend to be greatest for older individuals. For example, families headed by an individual age 65 or older would save about $1,575 per family (***Figure 80***). By contrast, average health spending would decrease by only $171 per family for younger age groups. On average, household savings would be greatest for families facing high out-of-pocket costs under current policy.

## J. Comparison of Policy Alternatives

***Figure 81*** presents a summary of the estimated cost and coverage impacts of the options analyzed in this study. For each policy option, this includes estimates of the number of people who would enroll, the reduction in the number of uninsured, net new state expenditures under the proposal, the percentage of children and adults with coverage under the proposal and costs per newly insured person. After reviewing these options, the steering Committee narrowed down the options for further consideration as shown in ***Figure 82***.

## Figure 79
## Change in Average Household Health Spending in Vermont Under the Single-Payer Model in 2001: After Wage Effects [a/ b/]

| Family Income | Single-Payer |
|---|---|
| **Less than $10,000** | ($608) |
| **$10,000 - $14,999** | ($721) |
| **$15,000 - $19,999** | ($1,000) |
| **$20,000 - $29,999** | ($1,038) |
| **$30,000 - $39,999** | ($1,238) |
| **$40,000 - $49,999** | ($1,397) |
| **$50,000 - $74,999** | ($995) |
| **$75,000 - $99,999** | $58 |
| **$100,000 - $149,999** | $933 |
| **$150,000 or More** | $4,490 |
| **All Families** | **($441)** |

a/ Excludes institutionalized people.
b/ Includes changes in premiums, out-of-pocket expenses, taxes earmarked to fund health reform, and after-tax wage effects.
Source: Lewin Group Estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

## Figure 80
## Change in Average Family Spending on Health Care in Vermont Under the Single-Payer Model in 2001 by Family Income and Age of Household Head: After Wage Effects [a/ b/]

| | Average Change by Age of Householder | | |
|---|---|---|---|
| **Family Income** | **Under Age 65** | **Age 65 and Older** | **All Families** |
| **Less than $10,000** | ($450) | ($1,006) | ($608) |
| **$10,000 - $14,999** | ($296) | ($1,396) | ($721) |
| **$15,000 - $19,999** | ($543) | ($1,961) | ($1,000) |
| **$20,000 - $29,999** | ($837) | ($1,567) | ($1,038) |
| **$30,000 - $39,999** | ($1,001) | ($2,482) | ($1,238) |
| **$40,000 - $49,999** | ($1,232) | ($2,351) | ($1,397) |
| **$50,000 - $74,999** | ($853) | ($2,081) | ($995) |
| **$75,000 - $99,999** | $229 | ($1,928) | $58 |
| **$100,000 - $149,999** | $1,191 | ($1,732) | $933 |
| **$150,000 or More** | $4,861 | $(357) | $4,490 |
| **All Families** | **($171)** | **($1,575)** | **($441)** |

a/ Excludes institutionalized people.
b/ Includes changes in premiums, out-of-pocket expenses, taxes earmarked to fund health reform, and after tax wage effects.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

## Figure 81
## Summary of Cost and Coverage Impacts for Coverage Expansion Options Studied for Vermont

| | Number Enrolled | Reduction in Uninsured People | Net New State Costs (in millions) | Percentage of Children Covered | Percentage of Adults Covered | Percentage of People Below 300% FPL Who Are Uninsured | State Cost Per Enrollee | State Cost Per Newly Insured Person |
|---|---|---|---|---|---|---|---|---|
| **Current Coverage** | | | | | | | | |
| **Current Coverage** | - - | - - | - - | 95.8% | 90.2% | 88.9% | - - | - - |
| **Income Eligibility Expansion for Parents under VHAP** | | | | | | | | |
| **Cover Parents Between 185% and 225% of FPL** | 1,500 | 552 | $1.0 | 96.0% | 90.3% | 89.1% | $666 | $1,811 |
| **Cover Parents Between 185% and 300% of FPL** | 4,400 | 1,242 | $1.9 | 96.2% | 90.5% | 89.3% | $432 | $1,530 |
| **Income Eligibility Expansion for Non-custodial Adults under VHAP** | | | | | | | | |
| **Non-custodial Adults Between 150% and 185% of FPL** | 4,500 | 4,278 | $9.5 | 95.8% | 91.1% | 90.2% | $2,111 | $2,220 |
| **Non-custodial Adults Between 150% and 225% of FPL** | 6,800 | 5,934 | $14.6 | 95.8% | 91.5% | 90.7% | $2,147 | $2,451 |
| **Non-custodial Adults Between 150% and 300% of FPL** | 8,600 | 6,624 | $15.4 | 95.8% | 91.6% | 90.9% | $1,790 | $2,325 |
| **Other Medicaid Options** | | | | | | | | |
| **VHAP Buy-in for Employers of Low-Wage Workers and People Below 300% of FPL** | 7,668 | 6,503 | $0.0 | 96.2% | 91.5% | 90.4% | $0 | $0 |
| **Expanded Outreach for Children** | 2,457 | 2,457 | $0.7 | 97.5% | 90.2% | 89.7% | $203 | $203 |
| **Outreach for Adults** | 7,549 | 7,549 | $9.9 | 95.8% | 91.8% | 92.8% | $1,331 | $1,331 |
| **Buy-in to Employer-Sponsored Coverage for VHAP Children** | 832 | 355 | ($0.2) | 96.0% | 90.2% | 89.1% | ($240) | ($563) |
| **Premium Subsidies for People Below 300% of the FPL without Access to Other Coverage (subsidy phase out between 225% and 300% of FPL)** | | | | | | | | |
| **Subsidy of $750 for Individuals, $1,500 for families** | 27,500 | 6,624 | $16.4 | 96.8% | 91.3% | 90.9% | $596 | $2,476 |
| **Subsidy of $1,000 for Individuals, $2,000 for families** | 28,200 | 7,728 | $22.6 | 97.0% | 91.5% | 91.2% | $801 | $2,924 |
| **Subsidy of $1,250 for Individuals, $2,500 for families** | 29,600 | 9,522 | $28.0 | 97.2% | 91.8% | 91.7% | $946 | $2,940 |
| **Employer Tax Credit for Non-insuring Firms (for 12 months) with Average Payroll Below State Average for Small Firms** | | | | | | | | |
| **Firms under 10 Workers: 25 Percent Credit** | 3,900 | 2,484 | $1.9 | 96.2% | 90.6% | 89.4% | $487 | $765 |
| **Firms under 10 Workers: 40 Percent Credit** | 5,500 | 3,450 | $4.1 | 96.3% | 90.8% | 89.6% | $745 | $1,188 |
| **Firms under 25 Workers: 25 Percent Credit** | 5,100 | 3,312 | $2.3 | 96.3% | 90.7% | 89.7% | $451 | $694 |
| **Firms under 25 Workers: 40 Percent Credit** | 6,700 | 4,416 | $5.0 | 96.5% | 90.9% | 90.0% | $746 | $1,132 |
| **Create Low-cost Coverage Options for Non-insuring Firms with Less than 25 Workers (for 12 months)** | | | | | | | | |
| **Three-year Exemption from Mandatory Benefits (assumes 5 percent savings)** | 1,350 | 1,350 | - - | 96.0% | 90.4% | 88.8% | $0 | $0 |
| **Mandatory Benefits Exemption with State-Funded Reinsurance Program (90% coverage for cases Over $25,000)** | 4,050 | 4,050 | $0.9 | 96.4% | 91.0% | 89.5% | $222 | $222 |
| **Single Payer Program** | | | | | | | | |
| **Basic Benefits Model (i.e., copayments with gatekeeper model)** | 609,000 | 51,390 | $0.9 billion | 100.0% | 100.0% | 100.0% | $1,559 | $18,486 |
| **No Cost-sharing Model (i.e., no copayments or gatekeeper program)** | 609,000 | 51,390 | $1.3 billion | 100.0% | 100.0% | 100.0% | $2,167 | $25,685 |

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

## Figure 82
## Summary of Cost and Coverage Impacts for Selected Coverage Expansion Options in Vermont

| | Number Enrolled | Reduction in Uninsured People | Net New State Costs (in millions) | Percentage of Children Covered | Percentage of Adults Covered | Percentage of People Below 300% FPL Who Are Insured | State Cost Per Enrollee | State Cost Per Newly Insured Person |
|---|---|---|---|---|---|---|---|---|
| **Current Coverage** | | | | | | | | |
| **Current Coverage Levels** | - - | - - | - - | 95.8% | 90.2% | 88.9% | - - | - - |
| **VHAP Expansion Options** | | | | | | | | |
| **Expand VHAP to Cover All Adults Through 300 Percent of the FPL** | 13,000 | 7,866 | $17.3 | 96.2% | 91.8% | 91.3% | $1,331 | $2,199 |
| **Outreach for Children's Coverage (assumes 50 percent effective)** | 2,457 | 2,457 | $0.7 | 97.5% | 90.2% | 89.7% | $203 | $203 |
| **Outreach for Adult Coverage (assumes 50 percent effective)** | 7,549 | 7,549 | $9.9 | 95.8% | 91.8% | 92.8% | $1,331 | $1,331 |
| **Buy-in to VHAP for Low-Wage Employers and People Below 300% of FPL** | 7,668 | 6,503 | $0.0 | 96.2% | 91.5% | 90.4% | $0 | $0 |
| **State Buy-in to Employer Coverage for Dr. Dynasaur Children** | 832 | 355 | ($0.1) | 96.0% | 90.2% | 89.1% | ($123) | ($391) |
| **Private Coverage Expansion Options** | | | | | | | | |
| **Employer Tax Credit for Non-insuring Firms with Fewer than 25 Workers Equal to 40 Percent of Employer Costs** | 6,700 | 4,416 | $5.0 | 96.5% | 90.9% | 90.0% | $746 | $1,132 |
| **Create Low-cost Insurance Option** | 4,050 | 4,050 | $0.9 | 96.4% | 91.0% | 89.5% | $222 | $222 |
| **Single-Payer Model** | | | | | | | | |
| **Basic Benefits Model** | 609,000 | 51,390 | $950.4 | 100.0% | 100.0% | 100.0% | $1,559 | $18,486 |

Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

These policy options were compared on the basis of their impact on the percentage of the population without insurance coverage. The BISCHA survey of households in Vermont indicates that about 91.6 percent of all people in the state have insurance coverage from some source. About 95.8 percent of children are covered and about 90.2 percent of adults are covered. In addition, about 88.9 percent of Vermonters living below 300 percent of the FPL are insured.

All of the options considered would result in some reduction in the number of people without coverage. However, only the single-payer model would achieve universal coverage. Aside from the single-payer model, the option having the greatest potential impact on coverage were outreach programs to enroll people who are already eligible for Medicaid/VHAP/Dr. Dynasaur who have not yet enrolled. Lewin estimated that an aggressive outreach program could raise the coverage level for children to 97.5 percent and the coverage level for adults in the state to 91.8 percent. Under the outreach option, about 92.8 percent of all people living below 300 percent of the FPL would be covered.

Analysis indicates that higher levels of coverage could be achieved by combining certain policy options. For example, if the state were to adopt all of the VHAP expansion options discussed above (e.g., outreach with eligibility expansion for adults etc.) except the VHAP buy-in program, about 97.5 percent of children and about 93.6 percent of adults would be insured (***Figure 83***). Adding the VHAP buy-in program would increase coverage for adults to 94.5 percent.

The state could also adopt a combination of the options designed to expand private insurance coverage. For example, providing the employer tax credit (40 percent credit for firms with fewer than 25 workers) together with the low-cost insurance product would increase coverage for both children and adults. However, coverage would reach only 96.7 percent among children and 91.1 percent among adults.

The state could also implement the full range of VHAP expansion and buy-in options together with the employer tax credit and the low cost insurance product. This scenario would reduce the number of uninsured by about 22,200 people, which is equal to about 43 percent of Vermont's uninsured population. Coverage under this combined policy would reach 98.0 percent among children and 95.3 percent among adults. The total state costs would be about 31.4 million, which is equal to about 1,400 per newly insured person. An analysis of reserve requirement for a buy-in program is presented in ***Appendix E***.

## K. Test Marketing

Based upon these analyses, the steering committee selected several options to be "test marketed" with uninsured people and employers. Action Research Inc. implemented this through a series of focus groups of uninsured people and employers. The results of these focus group sessions is presented in ***Appendix G***. The options selected for test marketing were:

## Figure 83
## Summary of Cost and Coverage Impacts for Selected Combinations of Expansion Options in Vermont

| | Number Enrolled | Reduction in Uninsured People | Net New State Costs (in millions) | Percentage of Children Covered | Percentage of Adults Covered | Percentage of People Below 300% FPL Who Are Insured | State Cost Per Enrollee | State Cost Per Newly Insured Person |
|---|---|---|---|---|---|---|---|---|
| **Current Coverage** | | | | | | | | |
| **Current Coverage Levels** | - - | - - | - - | 95.8% | 90.2% | 88.9% | - - | - - |
| **VHAP Expansion Options** | | | | | | | | |
| **Expand VHAP to 300 Percent of FPL with Outreach for Currently Eligible Children and Adults** | 23,024 | 18,227 | $27.7 | 97.5% | 93.6% | 94.6% | $1,200 | $1,540 |
| **ALL VHAP Expansion Options with VHAP Buy-In** | | | | | | | | |
| **VHAP Buy-In** [a/] | 25,536 | 20,373 | $27.7 | 97.8% | 94.5% | 94.6% | $933 | $1,376 |
| **Combined Private Sector Options** | | | | | | | | |
| **Employer Tax Credit with Low Cost Insurance Product** | 7,510 | 5,226 | $5.8 | 96.7% | 91.1% | 89.9% | $772 | $1,110 |
| **All Public and Private Options Combined** | | | | | | | | |
| **All VHAP Expansions, VHAP Buy-In, Tax Credits and Low-Cost Product** | 29,199 | 22,160 | $31.4 | 98.0% | 95.3% | 94.7% | $1,075 | $1,380 |

a/ Due to the expansion in eligibility to 300 percent of the FPL, the buy-in would apply primarily to employers.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

? **Direct Care Model:** The purpose of this program is to expand the availability of free or subsidized health care for needy individuals who continue to be uninsured. Uninsured people who present themselves at hospitals would be permitted to obtain services from participating physicians during regular business hours in the physician's office. Participants would be required to pay for a portion of the services provided on a sliding scale with income for people below 300 percent of the FPL (i.e. about $55,000 for a family of four). Case management would be provided for people with chronic conditions.

? **Medicaid Eligibility Expansion:** Income eligibility levels for the VHAP program would be increased to 300 percent of the federal poverty level (FPL) for all Vermont residents. This corresponds to annual income of roughly $35,000 for a single individual and $55,000 for a family of four. Because children through 300 percent of the FPL are already covered under Dr. Dynasaur, this would affect primarily adults between the current VHAP eligibility level and 300 percent of the FPL. (The current VHAP eligibility is 185 percent of the FPL for parents living with children; and 150 percent of the FPL for adults without children.)

? **VHAP buy-in to Employer Sponsored Health Plans:** The purpose of this proposal is to enroll Dr. Dynasaur eligible children in a parent's employer sponsored health plan in cases where such coverage is available. Under this option, the state would identify children eligible for Dr. Dynasaur who also have a parent with access to employer sponsored coverage where they work. The state would pay the premium contribution required to obtain family coverage under the employer plan in instances where this is less costly to the state than covering the children under Dr. Dynasaur. [45]

? **Employer Health Insurance Tax Credits:** The purpose of this program is to assist small employers with low-wage workers in obtaining coverage for their employees. The program would provide a refundable tax credit to eligible employers equal to the 25 to 40 percent of the employer's cost of coverage (e.g., premiums paid less the amount paid by employees).[46] The tax credit would be available to firms meeting the following eligibility criteria:

  ? Firms with 25 or fewer employees;

  ? Must not have provided coverage in the past 12 months; and

  ? Has average salaries/wages per employee below the statewide average

? **Develop Low Cost Insurance Product:** The purpose of this option is to make a low-cost health insurance product available to small firms that do not now provide coverage to their employees. Eligible employers would be permitted to purchase a private insurance policy that is exempt from state mandated benefit requirements and is subsidized with state funds.[47] The benefits excluded from the plan for eligible firms include chiropractic, home health, drug and

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[45] The amount paid to the employer would be equal to the difference between the contribution amount required for family coverage and the contribution amount required for single coverage under the plan.

[46] The tax credit would be refundable, which means that eligible employers would receive the tax credit even if they did not earn enough to pay taxes.

[47] The state funded subsidy would be in the form of a "re-insurance" program where the state pays 90 percent of the cost of benefits payments in excess of $30,000 for people covered under such a plan.

alcohol treatment, mental health and others. The plan would have a $500 deductible with a lifetime benefits limit of $100,000. Eligible firms include those that meet the following criteria:

? The employer has 50 or fewer workers with at least half enrolling in the plan;

? The employer has not provided coverage in the past 12 months;

? Less than 30 percent of the workers are earning over $30,000; and

? The employer pays at least half the premium

### *1. Test Marketing with Uninsured*

As with other groups, consumers without health insurance found the policy options difficult to digest and understand. Much of the time during the groups was spent describing and explaining different elements of the plans, rather than discussing the merits and drawbacks. However, the uninsured groups did seem to have a clearer grasp of certain of the concepts, specifically the Direct Care Model and the policies involving VHAP or Dr. Dynasaur. This is most likely because these groups are already familiar with the services. Participants tended to personalize their evaluations of the coverage options, often indicating preferences for options in terms of how beneficial the policy would be for their individual situation.

#### *a. Direct Care Model*

This coverage option was described as one that would "expand the availability of free or subsidized health care for the uninsured." It was described as a plan that would allow uninsured individuals to obtain medical care at a physician's office and would require some participants to pay for a portion of services based on a sliding fee scale.

Although consumers without health insurance were less confused about how the Direct Care Model would work than other groups, these participants did find parts of the description confusing and had many questions about how this policy option would work.

Participants were confused in thinking that the hospital would be the intake point for integrating uninsured Vermonters into the system. Participants thought this would mean that individuals would have to go to the hospital or emergency room each time they wanted to see the doctor, or that uninsured individuals would be denied care at emergency rooms and be told to see a physician during regular business hours.

Focus group participants suggested that there be other ways of getting the uninsured involved in the Direct Care Model, such as intake points at clinics, or an office that the uninsured could call or visit to apply for the program. Other suggestions included application by telephone or mail. Participants were particularly concerned that hospital staff would not have the time to properly screen individuals, process applications and distribute information on the program.

Participants were also confused about the income requirements for participation. Some thought that the sliding scale fee-for-service would apply to those whose household income was *no lower than* $53,000. Others were confused by this policy option because they did not understand that it is not intended to be a health insurance policy. Some wanted to know if pre-existing conditions would be covered under this plan.

Similar to the other groups, the uninsured participants also questioned whether it is feasible to assume that doctors would participate in such a plan. Participants wanted to know how the doctors would get paid for their services, what the reimbursement rates would be and how doctors could afford to treat people if they were not being fully paid for their services. All in all, there was skepticism about doctors' willingness to participate in the Direct Care Model.

Other concerns included who the participating doctors would be and what would happen in areas where no physician was willing to participate in such a plan. Would the Direct Care Model require that people have to travel far to obtain medical services from participating providers? What if a participant needed to see a specialist? How does this program address the cost of prescription drugs?

Uninsured participants raised one slightly different question about this policy option than was raised in the employer groups. They were concerned about the amount of paperwork that would be involved in participating in the program and how long it would take to get people integrated into the system.

However, despite their questions about the option, participants were generally very favorable toward the concept. They particularly liked the idea of being able to pay for services on a sliding scale fee-for-service basis. Participants in Middlebury indicated that a variation of this model exists now. They also note that they believe it is just not publicized well enough. They state that the existing program is not widely known about nor is information offered up to patients.

### *b. Medicaid Eligibility Expansion*

This coverage option was described as one that would "increase the income eligibility levels for VHAP to 300 percent of the federal poverty level (FPL) for all Vermont residents." The description noted that, since children whose parents earn up to 300 percent of FPL already qualify for Dr. Dynasaur, this plan would primarily affect adult Vermonters.

Overall, consumers without health insurance were favorable toward the idea of expanding Medicaid eligibility. Many participants believe that this plan will directly benefit more people than the other plans. Additionally, they see that Medicaid Eligibility Expansion is targeted toward the groups who need the most help – families with kids and low-income Vermonters. Participants also liked the idea that, rather than instituting a new program, this policy option builds on programs already in place.

Some participants did not like the idea of a gradual expansion of the program. Some felt that individuals without children should not have to wait for their coverage to begin, others questioned why the FPL eligibility requirements should be different for those with children and

those without. Overall, participants agree that help is needed for all Vermonters, sooner rather than later.

Participants expressed concern about the expansion of eligibility and the reimbursement rates for doctors. Participants note that, because reimbursement rates are low, doctors will not be willing to take on new VHAP patients. A few participants mention that an expansion of eligibility should be accompanied by an increase in the reimbursement rates. As mentioned in other groups, the consumers without health insurance would also like to see VHAP adopt a sliding scale policy for participants at the upper-limits of the income eligibility scale. Respondents suggested allowing VHAP participants "ease-off" the plan, by paying premiums, co-pays and deductibles in accordance with their income. This would allow VHAP participants to accept raises and/or higher paying jobs without losing their health insurance. For some it would also allow participants who do not have access to health insurance to participate.

In both focus groups with uninsured Vermonters, participants mentioned concerns about the amount of "red tape" and paperwork required for enrolling in VHAP. Participants in both groups also mentioned that they had heard that the state was planning to discontinue the VHAP program this coming October.

### *c. VHAP Buy-In to Employer-Sponsored Plans*

Consumers without health insurance had very similar reactions to the VHAP Buy-In coverage options as did participants in the employer groups. Initially, they liked the idea, however they expressed significant concern over the differences in benefits between Dr. Dynasaur and employer-sponsored plans. They were also concerned about the possibility that parents would not be able to choose whether to keep their children on Dr. Dynasaur or move them to a private plan.

Participants liked the idea that families would be covered under one plan and they felt that covering a spouse at no additional charge was a great benefit of this policy option. Most agree that the VHAP Buy-In would only be an acceptable policy option if the private insurer offered a similar level of benefit for the insured.

Both groups of uninsured Vermonters expressed concern that, under this policy option, the state would "force" people to purchase individual plans, even if a parent currently chooses not to be insured. Participants asked whether children would be denied coverage under Dr. Dynasaur if one of their parents had access to employer-sponsored health insurance, but choose not to enroll in the plan. It was noted that many people who have their children on Dr. Dynasaur choose not to accept employer-sponsored health insurance because of the cost. Others mention that a parent may choose not to accept an employer-sponsored plan because of the quality of the coverage being offered or because they do not want to do business with that insurer.

Participants wondered what effect this policy option would have on employers. However, in one group, participants thought this plan would be beneficial to employers, allowing them to have more insured people in their group and, therefore, to be able to bargain for better rates.

Similar to participants in the employer groups, participants were concerned about what would happen to children whose parents did not have access to employer-sponsored insurance. Would they be uninsured? Others questioned what would happen if a parent chose to take advantage of this policy and then was laid off. Would it be difficult for them to get their children re-enrolled in Dr. Dynasaur?

Overall, participants agree, with a few reservations, that the VHAP Buy-In to Employer-Sponsored Plans is a good idea. Most agree that people should not be forced to participate. Most also think that coverage under Dr. Dynasaur should be an option for anyone who found themselves laid off from their job or if the costs increased and the family could no longer afford their contribution to the employer plan.

### *d. Employer Health Insurance Tax Credit*

The final two options, the Employer Health Insurance Tax Credit and the Low-Cost Insurance plan were discussed briefly in the uninsured groups. Many of the participants found it difficult to switch gears from evaluating individual-targeted plans to evaluating employer-targeted plans. A number of participants simply found it difficult to evaluate the employer plans because they are not employers. Generally, participants agreed that the tax credit would be a good plan and would act as an incentive to employers to offer health insurance.

Uninsured participants did see many of the same drawbacks mentioned by participants in the employer groups. Most agreed that only offering the tax incentive to employers who have not been offering insurance is not fair to those who have been trying to help their employees. Participants also believe that the average wage requirements encourage employers to continue paying low wages so that they can qualify for assistance plans.

Some participants wanted to know how it would be determined if a company would receive a 25 percent reimbursement or a 40 percent reimbursement. One group suggested that the amount of the tax credit be correlated to the company's profitability, so that the least profitable companies would see the greatest benefit from this plan.

### *e. Low-Cost Insurance Plan*

Consumers without health insurance appreciated the Low-Cost Insurance Plan for the fact that the state was offering to help employers afford health insurance and because it would be available to companies with 50 or fewer employers. However, overall, these participants did not feel very positive toward this policy option.

Similar to the other focus group participants, the uninsured participants criticized this policy option because of the benefit exclusions. They found the benefit exclusions to be limiting and, therefore, perceive the plan to be less beneficial to the policyholder than other commercial plans would be.

Participants also expressed concern about the requirement that half of a company's employees must enroll in the plan. Some wondered if people who can not afford to pay the employee

portion of an employer's health insurance plan would be pressured into enrolling in a plan so that the whole company would be eligible.

Overall, the consumers without health insurance did not think that the Low-Cost Insurance Plan would be a significant incentive to get an employer to begin to offer health insurance. First, the uninsured saw that a 15 percent-20 percent savings in the cost of the premium is not significant enough of an incentive to get an employer to offer such a plan.

Secondly, they thought that the average wage earned requirement would encourage employers to continue to pay low wages.

### *f. Evaluating the Coverage Options*

Consumers without health insurance ranked the Direct Care Model and the Medicaid Eligibility Expansion highest of the three plans that they discussed in detail. Both of the plans were ranked highest because they were perceived to offer the most benefit to the most people.

Personalization of health insurance was an issue that contributed to the difficulty that many participants had in evaluating the policies. When evaluating a plan, participants often experienced significant confusion over the details of the plan. A large part of the time spent discussing each policy option was spent explaining details and clearing up misconceptions based on participants' reading of the policy. Often participants did not see how a particular plan would relate to their personal situation, and, therefore, did not know how to react to the plan. At times, respondents were able to step back and evaluate the options based on broader considerations, but it is important to note that they were mostly evaluating the plans based on their personal situations.

### *g. Summary and Recommendations*

In combining the recommendations for expanding coverage from the first focus groups with the results of the market testing, considerable consistency was noted between the initial recommendations and the coverage options that were developed. ***Figure 84*** contains a summary of the recommendations of uninsured individuals, the options that relate to each, and the evaluation of the various options.

## Figure 84
## Summary of Recommendations by Uninsured Individuals

| Recommendation | Coverage Option | Evaluation | Quote |
|---|---|---|---|
| Expand eligibility limits on existing state-funded health insurance plans | VHAP Expansion to 300 percent of Poverty | *Pros*<br>✍ Targets most needy people<br>✍ Builds on existing plans<br>✍ Could have sliding scale pay<br>*Cons*<br>✍ Doctors won't take it<br>✍ Red tape, paperwork | "There should be a soft outer limit for where income eligibility ends because people want to take that job and earn a little more money, but don't want to be penalized by losing all the benefits." |
| Insured should offer incentive to those who do not utilize the health care system often | None | | |
| Be able to tailor their plan to their needs | Direct Care Model | *Pros*<br>✍ Sliding scale<br>✍ Option exists now<br>*Cons*<br>✍ Point of access not clear<br>✍ Income requirements confusing<br>✍ Depends on docs' participation | "The sliding scale fee is probably the best thing about it. It gives everybody an option to be able to get access to some kind of medical care regardless of how much money they have or don't have." |
| Employers offer health insurance to part-time and seasonal employees | Employer Tax Credit | *Pros*<br>✍ Incentive to employers<br>*Cons*<br>✍ Not fair to firms already offering insurance<br>✍ Wage requirements encourage low wages | "This would probably encourage more employees to take out the extra family plan, since they are going to get help. That, in turn will help the employer because the more people he insures, the cheaper the policies are." |
| | Low Cost Insurance Plan | Pros<br>✍ Small insurers helped<br>Cons<br>✍ Not significant enough incentive for employers | "It tells more of what it excludes than of what it includes. It seems like it leaves out a lot." |
| | VHAP Buy-in | *Pros*<br>✍ Encourage firms to offer family plan<br>✍ Costs the state less<br>*Cons*<br>✍ Might not have equal benefits as Dr. Dynasaur | "This would be okay if it were optional. But if a parent can't afford the payment for individual insurance, their kid should still be able to get Dr. Dynasaur separately." |
| Educate people about plans that already exist | Outreach | None | "Publicity is an issue. This is about services that are already offered. The fact is a sliding scale does already exist. However, you are required to seek it out." |

## 2. Market Testing with Employers

Several focus group sessions were conducted with employers throughout the state. Most groups found the policy options difficult to digest and understand. Both employers and consumers had many questions about each plan. In most groups, participants indicated at some point that they did not feel that any of the options addressed what they believe are the core issues in insuring more Vermonters - affordable health care and affordable health insurance.

In nearly every group, participants raised concerns regarding eligibility requirements for participation in the plan. Participants did not like the idea of targeted, or, from their perspective, limited, assistance. Many groups wanted to discuss "affordable health insurance for all Vermonters." Whether it was the idea of tax credits for employers who have not been offering insurance or sliding-scale fees available to the uninsured, participants felt that all Vermonters were entitled to relief from the high costs of health care and health insurance.

### *a. Employer Health Insurance Tax Credits*

This plan was presented as one that would give a refundable tax credit to small employers of low-wage workers who begin offering health insurance to their employees.

Employers are very attracted to the idea of getting tax relief in exchange for offering health insurance to employees. A number of participants agreed that this policy option would encourage more employers to offer health insurance to employees. Additionally, some employers noted they appreciate that this plan allows employers the freedom to choose which plan they would like to offer.

Some also noted that they would like to see the amount of the credit increased to 40 percent-60 percent of employer costs. Consumers without health insurance suggested that the amount of reimbursement be tied to a company's profitability, so that the least profitable companies would see the largest proportional reimbursement.

Employers who are already offering health insurance to employees were upset by the eligibility requirement that would prohibit them from taking advantage of this policy. Participants in other groups also felt this requirement was not fair. Most groups recognize that affordable health insurance is a problem for most small businesses, not just those that do not offer insurance.

Participants also recognize that, although this policy option would help, many employers cannot afford the cash output required to pay the premiums on a monthly basis. These participants noted that the Employer Health Insurance Tax Credit does not address the need for more affordable health insurance premiums in Vermont. A few also noted that this policy does not address the fact that many low-wage workers cannot afford to pay their share of the premium required to join an employer-sponsored plan.

Many thought that requiring the firms' average wages to be below the statewide average would be limiting to many businesses. Employers cited the fact that in today's economy, they have had to raise their wages to be competitive. Others noted that their particular industry or location (such

as Chittenden County) required them to pay higher-than-average wages and, therefore, they would not be eligible.

### *b. Low-Cost Insurance Plan*

This plan was described as an insurance policy that would cost 15 percent to 20 percent less than other commercial plans. The plan would exclude state-mandated benefits and the state would offer a reinsurance program for 90 percent of benefit payments in excess of $30,000.

This policy option was widely considered a good plan for those who do not have any other choices. Overall, it was viewed as a moderately adequate solution to the health insurance problem facing employers. Many liked the idea that a low-cost plan would be available; however, contrary to early findings, most felt the excluded benefits were a major drawback to this plan.

Respondents agreed that in earlier focus groups they championed the idea of being able to purchase a plan free of state-mandated benefits. The difference between what they described earlier and the Low-Cost Insurance Plan was that this plan did not address the deregulation of the insurance industry, which they believed would increase competition and lower prices.

Some participants indicated that they were not aware that benefits such as home health care and drug and alcohol treatment were state-mandated benefits – and they felt insurance plans should cover those services. Others noted that many people utilize chiropractic and mental health services. Some agreed that the benefits exclusions were an acceptable way to achieve "cheap" health insurance coverage; however, most agreed they would not want to be covered by such a plan.

Many participants agreed that a 15 percent to 20 percent savings would not be enough to justify purchasing a plan with significantly fewer benefits than other plans. It was noted that a 15 percent to 20 percent price reduction would barely cover a single year premium increase at the rate that health insurance companies have been raising premium rates.

Every group was significantly confused by the reinsurance portion of this policy option. Many thought that it meant the employers had to pay out $30,000 in health insurance expenses before the plan would begin to assist them; others thought that the employer would be responsible for paying the first $30,000 in benefit payments.

Respondents also criticized participation requirements. They believed that the employee income caps were too low; that some employers of low-wage workers would not be able to afford half of the premium, and that it would be difficult to get half of the employees in low-wage firms to agree to sign up for the plan. Most also agreed that a $100,000 lifetime benefit cap was too low.

### *c. VHAP Buy-In to Employer-Sponsored Plans*

This plan was described as one that would shift children from Dr. Dynasaur to a parent's employer-sponsored health plan. This would be done only in instances where it would be less

costly to the state to pay the difference necessary to obtain family coverage on the private plan than to keep the child enrolled in Dr. Dynasaur.

Initial reactions to this policy option were good. Participants liked the idea that the plan would save the state money and that it would assist individuals in affording private insurance. Many appreciated the individual-targeted approach.

However, participants noted that Dr. Dynasaur benefits are often far superior to benefits available in an employer-sponsored plan. They also mentioned that the policy option would increase costs to individuals, because most employer plans have co-pays and deductibles, which individuals were not paying under Dr. Dynasaur. Participants looked significantly less favorably on the plan when they realized that, although the state would save money, individuals would end up with more out-of-pocket medical expenses.

Participants were concerned that many parents would be unwilling to move their children from Dr. Dynasaur to an employer's plan. Questions were raised about whether people would be required to move their children, against their wishes. Many also wondered what would happen in cases where a parent is offered insurance, but chooses not to be insured for cost reasons. Would that person be required to pay the individual premium portion, so the state could shift the children to the employer plan?

There were also concerns about the state's involvement in the administration of this plan. Most agreed they did not want the state making decisions about who should be on which insurance program. Many also anticipated a significant amount of bureaucracy and paperwork, requiring many administrative personnel. Many questioned whether the state had the current capacity for this additional work.

Questions were raised regarding whether shifting a number of children from Dr. Dynasaur to private insurance would increase health insurance premiums for all. Many thought that this would be the case. However, consumer without insurance believed that adding more people to private insurance policies would give employers more bargaining power to get lower premium rates.

As with other policy options, many note that this plan does little to address the need for lower premium costs or more affordable health care. They also criticize the plan for being selective about who receives assistance, noting that this plan would only help those who are already offered health insurance and would do nothing for people without access to insurance.

### *d. Direct Care Model*

This plan was presented as one that would provide funding to expand the availability of free or subsidized health care for the uninsured.

This policy option was perhaps the most confusing to nearly all of the groups. Many could not understand that this was not a health insurance program, nor could they understand how this program would work. Many were cynical about a doctor's or a hospital's willingness to

participate in another program that did not charge full fees for services. Participants used Medicaid and Medicare as examples and insisted that there would be no such thing as free care.

Consumers without health insurance were not as confused by this policy option. They were slightly less cynical about doctors' and hospitals' willingness to participate in such a system. Despite this, they had many of the same questions and concerns as those in other groups had.

Participants believed that someone, somewhere, would end up paying for the care delivered under this model. Most believed the burden would fall upon taxpayers and insured people in the form of higher taxes and higher premium rates.

The perception is that doctors are already overbooked, because many people have difficulty getting in for appointments. Therefore, many questioned how doctors would be able to fit in new patients from this plan. Many also believe that doctors are reluctant to take Medicare and Medicaid patients, because of low reimbursement rates. Given this, they question a physician's willingness to take on more patients who would not be paying full cost for their services.

Additionally, many believe that this option is targeted toward a group of people who are most likely already eligible for other types of assistance. Participants also mentioned that this program does not address the issue of affordable health insurance and care for all Vermonters.

Despite the confusion over this model, many did praise it for getting people access to health care and helping them afford it. Many agreed that the plan would reduce the cost of caring for the uninsured by integrating them into mainstream care, getting access to preventive care and reducing the need for emergency room visits.

### *e. Medicaid Eligibility Expansion*

This plan was presented as one that would expand the income eligibility levels for VHAP to 300 percent of the federal poverty level for all Vermonters. The increase would be implemented gradually.

Many thought that this policy option was a good idea. They see that this policy option would achieve the goal of insuring more Vermonters, specifically addressing the needs of uninsured adults in Vermont. Many preferred this plan because it targeted individuals rather than employers. This plan was also seen as one that would address the need of Vermonters who work multiple part-time jobs or hold seasonal positions and, therefore, are not eligible for employer-sponsored health insurance.

Again, participants took issue with some of the eligibility requirements. A few felt that 300 percent of the FPL was too high; however, most felt that 300 percent did not go far enough. Many thought that the eligibility levels should be increased at the same time for everyone, regardless of whether or not they have children.

One concern voiced about this policy option is whether it would cause more people to drop employer-sponsored coverage, thus making it more difficult for employers to qualify for plans or to afford the premiums. Another concern is that this option will end up costing taxpayers more.

Uninsured respondents and one group of employers who do not offer health insurance note that expansion of VHAP will increase the cost shifting that occurs due to the reimbursement rates.

Participants did mention they would like to see a gradual move off VHAP, rather than a strict cutoff. Respondents thought that those over 300 percent of the FPL should be allowed to participate in VHAP, but pay premium payments, deductible and co-pays. They envision that these payments would increase the higher one's income level was.

### *f. Comparing the Options*

Each group was asked to rank the three policy options they evaluated in depth. Participants from businesses not currently offering insurance named the Employer Health Insurance Tax Credit as their first choice and the Low-Cost Insurance Plan as their second choice. The VHAP Buy-In was the third choice.

Employers who are offering health insurance to employees were most likely to select the VHAP Buy-In to Employer-Sponsored Plans as their first choice. The second choice was the Employer Health Insurance Tax Credit and the lowest-ranked plan was the Low-Cost Insurance Plan.

Generally, employers gave the highest ratings to the plans that they felt would benefit them most directly. In fact, many employers who do offer health insurance noted that they did not really prefer any of the plans, because none were targeted toward them and their struggles with offering health insurance.

The consumers who have health insurance had very different opinions on which of the individual-targeted plans rated first. In Rutland, respondents named the VHAP Buy-In as their first choice; in Bennington, respondents preferred Medicaid Eligibility Expansion. Consumers without health insurance ranked the Direct Care Model and Medicaid Eligibility Expansion as their first choice.

Near the end of each group, respondents were asked to vote on all five plans that had been presented and discussed. Two out of three indicated they would support the Employer Health Insurance Tax Credit and Medicaid Eligibility Expansion. Half supported the idea of the VHAP Buy-In to Employer-Sponsored Plans or the Direct Care Model. About one in three supported the creation of a Low-Cost Insurance Plan.

Perhaps not surprisingly, employers who do not offer health insurance are most likely to support the programs targeted toward employers not currently offering insurance (Employer Health Insurance Tax Credit and Low-Cost Insurance Plan). Employers who do currently offer health insurance prefer the individual-targeted plans (Direct Care Model and Medicaid Eligibility Expansion). Interestingly, consumers who have health insurance spread their support among the Employer Health Insurance Tax Credit, the VHAP Buy-In and the Medicaid Eligibility Expansion; those without health insurance supported all of the plans except the Low-Cost Insurance Plan.

## L. Policy Recommendations of the Steering Committee

This section summarizes the recommendations made by the steering committee based upon the evaluation of the policy options discussed above. It is important to note that Vermont has had considerable success in increasing access to health coverage over the last decade. Coverage expansions are difficult to achieve without concomitant federal support or action. Particularly in the current economic climate, States cannot do it alone. Many of the populations that could be reached with available federal policy options have already been covered. It was evident based on the analyses performed for the Steering Committee that no single strategy, other than a tax financed system, was available to reach all of the 8.4 percent uninsured in Vermont. Increases in the level of coverage considered by the Steering Committee to represent reasonable interim coverage goals were to:

? Provide coverage for 95 percent of Vermont adults

? Provide coverage for 97.5 percent of Vermont children

A major finding is that the remaining hard-to-reach cases are part of a diverse group of individuals, ranging from the 36 percent of uninsured who are eligible for public programs and not enrolled to those working adults who reject employer-sponsored health insurance. As such, recommendations from this project address the varying pockets of uninsured individuals with incremental solutions rather than a single policy initiative.

As discussed above, for each option considered by the Project Team and Steering Committee, Lewin estimated the number of people who would become insured and the cost of subsidies provided under the program. This includes estimates of the cost to the State and costs to the federal government under policies where federal matching funds are available. All of the options considered by the Steering Committee would result in a reduction in the number of uninsured. Aside from the single-payer model, the option having the greatest potential impact on coverage were outreach programs to enroll people who are already eligible for Medicaid, VHAP or Dr. Dynasaur who have not yet enrolled. However, the capacity of the VHAP program to serve additional enrollees and receive federal funds in constrained based upon the budget neutrality provisions of the 115a waiver.

Findings from the project analysis resulted in the conclusion that higher levels of coverage could only be achieved by combining the various policy options. For example, if the state were to adopt all of the VHAP expansion options discussed above (e.g., outreach with eligibility expansion for adults etc.), except the VHAP buy-in program, about 97.4 percent of children and about 93.6 percent of adults would be insured. Adding the VHAP program would increase coverage for adults to 94.5 percent.

Similarly, a combination of the options designed to expand private insurance coverage would also raise coverage levels. For example, providing the employer tax credit (40 percent credit for firms with under 25 workers). However, coverage would reach only 96.7 percent among children and 91.1 percent among adults.

Given favorable economic conditions, implementing the full range of VHAP expansion and buy-in options, together with the employer tax credit and the low cost insurance product would reduce the number of uninsured by about 22,200 people, which is equal to about 43 percent of Vermont's uninsured population. Coverage under this combined policy would reach or exceed the defined targets: 98.0 percent among children and 94.7 percent among adults.

**The policy recommendations of the Steering Committee are presented below.**

1. *In the short term Vermont should direct resources toward maintaining existing levels of coverage*

In Vermont, approximately 91.6 percent of all people have insurance coverage from some source. About 95.8 percent of children are covered and about 90.2 percent of adults are covered. Given the bleak short-term economic forecast, Vermont should focus its efforts toward maintaining this existing level of coverage.

2. *The target goal of 97.5 percent coverage of children can be met without new program initiatives. The Agency of Human Services should continue current outreach initiatives to eligible children not enrolled in Dr. Dynasaur*

The State could achieve the interim enrollment goal for children by increasing enrollment in existing programs, especially Dr. Dynasaur. Vermont has already implemented a number of initiatives to increase enrollment of children, including media campaigns and outreach through schools, providers and other groups. Outreach programs that are being conducted in schools and with employers could be expanded. The State should carefully consider any further changes in premiums. Research indicates that participation is reduced by about one-third in cases where a premium is required, even where the premium is as low as $10 per month.

3. *Coverage should be expanded incrementally based on the State's financial capacity*

The Steering Committee's analyses identified that multiple incremental strategies will be necessary to make health insurance available to everyone. State initiative should focus on uninsured Vermonters at or below 300 percent of the federal poverty level (FPL). As noted above, statewide coverage targets for Vermont are defined as 95 percent of adults and 97.5 percent of children and could only be reached through a multifaceted approach and a robust economy.

**The specific recommended initiatives described in detail in Section 4 of this report are:**

? ***VHAP Buy-In*:** The VHAP program could be used to provide a lower cost coverage alternative for individuals and employers. For example, individuals without access to employer coverage living below 300 percent of the FPL could be permitted to purchase coverage under the VHAP program by paying a premium. Similarly, small employers could be given the option of purchasing coverage for their employees and dependents through VHAP. The benefits provided under the "buy-in" option would be the same as those provided under the current VHAP program. However, buy-in participants would be required to pay a

premium equal to the full cost of their coverage (i.e., average cost per enrollee). Although participants would be required to pay the full premium for coverage, it is still likely to be a lower than the cost of purchasing comparable coverage in the private sector. This is because provider payment levels under the VHAP program are generally substantially lower than payments rates under private plans. In addition, administrative costs under VHAP are generally lower than in private plans because there are no commission payments to brokers and agents, and there is no allowance for insurer profits. Adjustments of provider payment rates to Medicare levels would be made under this option.

? ***Incrementally Expand VHAP up to 300 Percent of Federal Poverty Level*****:** Income eligibility levels for the VHAP program would be increased incrementally to 300 percent of the Federal Poverty Level (FPL) for all Vermont residents. This corresponds to annual income of roughly $25,000 for a single individual and $53,000 for a family of four. Because children through 300 percent of the FPL are already covered under Dr. Dynasaur, this would affect primarily adults between the current VHAP eligibility level and 300 percent of the FPL. (The current VHAP eligibility is 185 percent of the FPL for parents living with children; and 150 percent of the FPL for adults without children.) The expansion would be implemented gradually. For instance, the expansion might begin by increasing eligibility levels for parents living with children to 200 percent of the FPL, then gradually increasing to 250 percent, etc. Then consideration could be given to expanding eligibility for adults without children.

? ***Create a Small Employer Tax Credit***: An approach to expanding coverage would be to provide subsidies directly to employers to help them provide coverage to their workers. This could be accomplished through a refundable tax credit to employers who are not now providing coverage. Existing proposals for an employer tax credit would set the amount of the tax credit equal to a percentage of the of the employer's expenditures for employee health benefits (e.g., 25 to 40 percent).

Eligibility would be limited to: (1) firms that have not provided coverage for at least 12 months; and (2) firms with an average payroll below the average for small firms in the state. These firms would receive these tax credits for a period of three to five years as long as the firm continues to meet the firm size and average payroll eligibility criteria. The dollar amount of the credit could also be phased-out with percentage reductions each year over the three to five year period.

Options are available to vary the credit by amount and firm size:

? Firms with 10 or fewer workers - 25 percent credit;

? Firms with 10 or fewer workers - 40 percent credit;

? Firms with 25 or fewer workers - 25 percent credit;

? Firms with 25 or fewer workers - 40 percent credit.

In addition, the following two models were discussed in some detail by the Steering Committee during their deliberations. The Direct Care Model offers an interim, but important safety net for

Vermonters without health insurance and who are not eligible for existing programs. It differs form other strategies in that it is not insurance coverage, but offers the direct provision of basis health services. The single-payer system also differs in that it represent a fundamental restructuring of health care financing, moving from a mix of public and private financing to a universal, tax based financing system. It has significant implications for the private insurance market, current insurance and coverage arrangements, and offers the guarantee of universal coverage for all Vermont residents. A summary of the perspective of the Steering Committee on these two approaches is discussed below.

### *The Direct Care Model*

The Steering Committee recommended that the direct care model be supported and resources provided to foster this approach. Vermont currently has a number of avenues for uninsured individuals to receive health care in the community. Vermont has a system of traditional and integrated free clinics, and Federally Qualified Health Centers (FQHCs). Several sites of well-organized, integrated free clinic direct care programs exist in Vermont. The Gifford Medical Center in Randolph, Mt. Ascutney Hospital and Health Center in Windsor, and Fletcher Allen Health Care in Burlington run excellent examples of the direct care model, with other hospitals considering this approach. Although these programs do not provide "health care insurance coverage" as traditionally understood, they provide an important source of care for many individuals that is often the preferred source of care for some of the participants of these programs. One compelling characteristic of the Direct Care Model is that it is locally based and thus can be tailored to the needs of the patients and providers in each community, and represent a modest investment at the state and local level.

The FQHCs provide comprehensive community based primary care. The feature of the FQHCs that is particularly important in relation to the Direct Care Model is that they provide care on a sliding fee schedule basis for uninsured individuals, and as such serve as a safety net for these individuals. There are five FQHC sites in Vermont.

The recommendation of the Steering Committee is to both support and expand this effort where possible, and to provide such support as is necessary to foster the evolution of this service model. The Steering Committee did not see this as a long term substitute for insurance coverage for all Vermonters, but one that can provide necessary care that builds upon an existing structure and will possibly bring Federal or other non-State revenue into Vermont.

### *The Single-Payer Model*

The Lewin Group prepared an analysis of the single-payer model for the Steering Committee. This model is not an incremental approach to covering the remaining uninsured using the existing public and private insurance systems operating in Vermont. Rather it would fundamentally alter the financing of health services in the State. It is the only approach considered that would achieve universal access and as such had strong proponents within the Steering Committee process. Likewise, it also would require a public commitment to a tax financed system and would have significant implications for the private insurance market, businesses that both provide employee health benefits and those that do not, and individuals. These implications were of concern to opponents of this approach. The single-payer did not have

sufficient support from the Steering Committee members to include it among the approaches that were "field/market tested" during the State Planning Grant process. The analysis performed by the Lewin Group details the changes and potential impacts of this model. The full report on the single-payer model is included in the appendix to this report.

## SECTION FIVE: CONSENSUS BUILDING STRATEGY

The Steering Committee included representatives of various State agencies and private organizations. All of these representatives worked together on the development of coverage options within Vermont. This section summarizes the process used both to achieve collaboration among stakeholders as well as achieve consensus on the policy options selected.

### A. Compilation of HRSA- Related Activities

Because the Steering Committee members represented a diverse group of stakeholders and were involved with health policy and other groups, one of the early activities in the process was to identify other groups and projects related to our work. It was felt that the HRSA project could benefit from the findings of these other groups, and that the "whole was greater than the sum of the parts." These activities are described below.

#### *1. Governor's Commission on Health Care Availability and Affordability.*

This bipartisan group was charged by Governor Howard Dean in his 2001 State of the State Address to "study data and travel the state talking to employers and others concerned with rising health care costs to find ways to achieve the dual goals of controlling costs and guaranteeing universal access. Their task was to lay the groundwork so that the Legislature and the people of Vermont can begin to reach consensus on how to proceed." Specifically, this commission:

? Studied data and information relative to (i) increasing health care costs, (ii) cost shift, and (iii) availability of services;

? Talked with employers and others concerned with rising health care costs and access to health care;

? Identified ways to achieve the dual goals of controlling costs and guarantee universal health care access; and

? Reported to the legislature and the Governor on the Commission's findings and lay out recommended approaches to address these problems.

The Bipartisan Commission on Health Care Availability and Affordability will issue its final report on or about November 10, 2001.

#### *2. Commission on the Public's Health Care Values and Priorities (PHCV&P)*

The Commission was formed to provide a mechanism for continuing public discussion and input regarding Vermont's health care system, creating and using a long-lasting model for citizen dialogue.

The goals of the commission are:

? Have a public that is better informed on health care issues and information.

? Determine the public's values related to societal access to health care.

? Determine the public's priorities and preferences for how to provide societal access to an appropriate level of health care.

Current activities of this Commission include a random digit dial survey of Vermonters to identify their health choices. Support from the Agency of Human Services will allow this Commission to expand the scope of the survey, compare the results with a similar survey done 5 years prior to see if Vermonters values, priorities and choices, values and priorities related to health care have changed and how, and to report to the State Planning Grant Steering Committee.

### *3. Vermont Ethics Network (VEN)*

VEN received a grant from the Study Circles Fund (Topsfield Foundation) to develop and conduct a series of weekly "study circles" for 40 regional study groups of 8-12 participants each to discuss Access to Health Care in Vermont. VEN then partnered with the Commission on the Public's Health Care Values and Priorities for the purpose of distributing PHCV&P questionnaires to study circles participants in order to compare and contrast the health choices between self-selected individuals (participants in the study circles) and those randomly chosen for the telephone survey. Facilitators for the study circles were trained in September and some circles have started. While a few circles will take place during the Fall, the project's kick off day and press conference scheduled for September 11, 2001 were rescheduled for mid-January 2002. A final report is projected in March 2002.

### 4. *Vermont Business Roundtable*

The Vermont Business Roundtable is creating an employer guide to controlling health care costs through benefit plan design and use of corporate wellness programs. This guide will provide models of successful programs from within Vermont and from other markets. These models will include incentives for positive personal health behavior, emphasize wellness and prevention, and encourage effective utilization of health services and the control of health care costs.

This guide will provide guidance and information on benefit design options including: an assessment of employer considerations when purchasing a health plan; a summary of cost benefit design options; and benefit design models that include wellness and health promotion.

The desired outcomes of this project include better informed employers, healthier and more productive workforces, increased awareness of personal responsibility, and more effective control of overall benefit and health care costs. This project will be completed in the winter of 2002.

### *5. The Vermont Coalition of Clinics for the Uninsured (VCCU)*

The Vermont Coalition of Clinics for the Uninsured (VCCU) is a group of free medical care clinics (and one dental clinic) in Vermont which work together to provide a safety net of primary care services to individuals whose household incomes fall below 200% of the federal poverty

level and who either lack health insurance entirely or are under-insured (e.g., high deductibles). The nine member clinics are distributed around the state and although each has its own board of directors, maintains its own policies, and does its own fund-raising, some funding from the State of Vermont and private foundations comes through the coalition. In addition to providing direct primary care at no or minimal cost, the coalition actively advocates for its constituents.

There are two different models of clinics in the coalition. The majority of the clinics operate as "traditional" freestanding facilities, staffed by volunteers; these clinics offer services to the uninsured through occasional (weekly to tri-weekly) clinic evenings. Several of the formerly traditional clinics now operate as an "incorporation" model. Rather than providing a separate set of services for the indigent, these clinics operate through local hospitals and medical care practices to incorporate their clients into the mainstream provision of health care services.

The VCCU is researching differences between the two models with respect to the following issues:

? Socio-demographic characteristics (e.g., age, gender, income, family structure) of the client population;

? Medical/health status (e.g., presenting medical condition, necessary referrals) of the client population;

? Numbers of clients served as a percentage of the uninsured in the catchment area;

? The range and accessibility of services provided;

? The cost per client served; and

? Selected measures of client outcomes.

### *6. Vermont Department of Health*

? Behavioral Risk Factor Surveillance Survey: On-going telephone survey of approximately 4200 Vermonters annually. Includes questions of health insurance, use of health services, health status and risk factors.

? Health Care Provider Survey: Biennial survey of physicians, nurse practitioners, physician assistants and dentists. Includes demographics, specialty, hours worked, practice location, practice characteristics and other items. Registered and licensed nurses added in 2001.

? Federal Designations of Underservice: Analyze service areas, request new or renewed designations for primary care, mental health and dental health. Also recommend Governors Designations.

? Loan Repayment Program: Payments on behalf of primary care providers, psychiatrists and dentists to cover part of outstanding educational loans in return for commitment to practice in

underserved and rural areas. Administered by the Area Health Education Centers and linked to Freeman Foundation Award program.

? Critical Access Hospital Program: Special designation of small community hospitals to improve financial stability. A component of the Rural Hospital Flexibility Program.

? Grants to Vermont providers to support access initiatives: Coalition of Clinics for the Uninsured, Burlington Community Health Center, and Vermont Recruitment Center.

? Personal assistance: Enrollees in VDH programs (WIC, CSHN, HIV, etc.) receive assistance with applying for and using health insurance.

? Development and distribution of practice guidelines: Reportable infectious diseases, immunization, diabetes, lead screening, child periodicity schedule, adult clinical preventive services.

? Healthy Vermonters 2010: Outcome objectives and measures related to health status, access to health services and risk factors.

? Vermont Health Plan 1999: Long term goals for improved health focusing on the major determinants of health: biology, socio-economic status, health behaviors, the environment and the health care system.

? Rural Hospital Flexibility Program: Grants and technical assistance to community hospitals and others to improve networking, emergency services and the quality of health care.

### *7. Covering Kids*

Vermont began work in September 1999 with grant funding from the Robert Wood Johnson Foundation. Each state has some version of this program. Its purpose is to take whatever steps may be necessary to reduce the number of uninsured children in the state – with particular attention to those children eligible, but not enrolled, in Dr. Dynasaur. The program is a public-private partnership, managed by representatives of several agencies of state government, and several private-sector organizations. While much of the initial effort was focused on understanding which children were uninsured, and how they might be better reached, the program also focuses its effort on outreach, and simplification of the enrollment processes. A key component of the program is the work of the 12 regional partnerships throughout the state. With funds made available from the grant, these partnerships have touched bases with a multitude of community organizations, agencies, and individuals to enlist their aid in the program's efforts. The initial grant period for the program is three years. However, the Foundation has recently announced its intention to extend the program for four more years, expanding it with a new title: "Covering Kids and Families".

## B. Steering Committee Composition and Communicating with Other Groups

The Steering Committee was comprised of representatives from a variety of constituent groups, including providers, employers and advocacy groups, as well as legislators from the Health and

Welfare Committees of the House of Representatives and the Senate. In addition to legislative representation, the following groups each sent a representative to the Steering Committee: the Bi-State Primary Care Association; the Vermont Business Roundtable; the Vermont Chamber of Commerce; the Commission on the Public's Health Care Values and Priorities; the Department of Banking, Insurance, Securities and Health Care Administration; the Vermont Agency of Hospital and Health Services; the Vermont Medical Society; the Vermont Coalition of Clinics for the Uninsured; the Vermont Program for Quality in Health Care; Legal Aid's State Ombudsman's Office; the Vermont Department of Health; BlueCross BlueShield of Vermont; the Agency of Human Services Department of Prevention, Assistance, Transition and Health Access (PATH); and the Veteran's Administration Hospital. And Regional Medical Center.

The Steering Committee met monthly, with meetings open to the public. Any interested people were put on the Steering Committee meeting notice email list to receive copies of minutes and notices about meetings. A link to all reports generated was established on the PATH web page.

Many Steering Committee members also serve on other committees and commissions, and thus were able to bring information from and give regular updates to their respective constituent groups. Several members regularly attended meetings of the Bipartisan Commission on Health Care Availability and Affordability, and the legislative Health Access Oversight Committee. In addition, through the Steering Committee, The Lewin Group made several formal presentations to these two groups. In addition, the Lewin Group formed a work group of insurers and providers to obtain their perspectives. The results of these groups are summarized in ***Appendix A*** and ***Appendix B***.

## C. Understanding Coverage Options

Reports from the qualitative research as well as an array of coverage policies and options were discussed in the initial meetings of the Steering Committee. In order to begin the process of systematically examining the options and finding consensus among the diverse groups represented by members of the Steering Committee, a conceptual framework was presented at the March meeting. Four broad coverage option types (or "buckets") were described in which to place the various options: Public program expansion models, private sector expansion models, a single-payer model, and the clinic models (not to be confused with the 'free clinics'). The Lewin Group also provided a review of approaches used in other states to expand coverage. A copy of this presentation is contained in ***Appendix C***.

Although not a coverage option but an access policy, the clinic model (later called the "direct care model") was discussed although not completely developed. It was considered by the Steering Committee to be a transitional model of direct care provision designed to provide uninsured people with continuity until a stable source of insurance or financing is available. The model consists of community-based services that are organized and implemented by local citizens and institutions to assure access to health services by all in the community. The model emphasizes primary and preventive care and provides assistance when needed to access additional care such as specialty care or pharmacy. Patients are integrated into on-going primary care and treatment systems. It is not a formal "insurance" program, but providers agree to see clients based on local criteria and have the right to refuse to provide some services or some

individuals. There is no "out of area" coverage except as defined by referral arrangements with tertiary care centers. The “direct care model” does not replace existing insurance programs.

## D. Evaluating Coverage Options

During this phase of the project, The Lewin Group evaluated the cost and coverage impacts of a wide range of options for expanding insurance coverage in Vermont. For each option, Lewin estimated the number of people who would become insured and the cost of subsidies provided under the program. This includes estimates of the cost to the State and costs to the federal government under policies where federal matching funds are available.

The Steering Committee employed an inclusive process of consideration during this phase of the project. The committee preferred to vote in favor of removing options from consideration than vote in favor of options, with the result that two models (Single-Payer and Premium Subsidies for Low Income workers) did not receive committee support for field testing. The committee, however, was reluctant to take other options off the table. Within each of eight general types of policy options, Lewin examined several variants to show the sensitivity of program costs and coverage impacts to various design parameters.

In considering options that other states had either implemented or considered, experts from those states (Kansas and New York) were brought in to report first hand on their experiences.

## E. Selecting Coverage Options

The Steering Committee met for a daylong session led by an outside facilitator in order to make final selection of the options and reaffirm the coverage goals that had been implicit throughout the project. In addition to identifying strategies to make health insurance available to everyone at or below 300% of the federal poverty level (FPL), statewide coverage targets were defined as 95% of adults and 97.5% of children.

ASSUMPTIONS: To help evaluate the various options, the group developed and adopted a list of assumptions:

- ? Public program eligibles should be included in uninsured count
- ? Those eligible, but who do not enroll, require a different strategy to get them coverage
- ? Costs (medical care, insurance) will increase
- ? Available dollars will decrease
- ? Pressure on the uninsured will increase
- ? “Affordable” is subjective
- ? “Coverage” is subjective
- ? The “value” of insurance is subjective (Perceived value of insurance…)
- ? State revenues will deteriorate / have deteriorated

CRITERIA: The Steering Committee was then led through a process to identify and rate criteria for evaluating the options. Top criteria for rating the options included cost effectiveness, having identifiable revenue sources, increasing the number of people covered, being administratively simple, not shifting costs disproportionately, and being eligible for a Federal match. Additionally, it was felt that options should first focus on providing coverage to lower income Vermonters. A complete list of the criteria, in order of the group's support, follows:

- ? 90% Option(s) should have identifiable revenue sources
- ? 88% Option(s) must be cost effective to implement
- ? 88% Costs should not be shifted disproportionately to any entity (all must share in the cost)
- ? 83% Option(s) should increase the number of people covered
- ? 83% Eligibility for option(s) should be geared to ability to pay
- ? 81% Option(s) should be administratively simple
- ? 78% Option(s) should focus first on coverage for lower income before higher income
- ? 67% Option(s) should have Federal $ draw
- ? 64% Option(s) should increase the sense of personal responsibility
- ? 55% Option(s) must have focus group support
- ? 50% Option(s) should have quick implementation
- ? 24% Option(s) should not increase taxes

AFFINITY CHART WORK: The options were described on easel sheets and grouped into three 'families' of options and posted in different sections of the meeting room. The committee divided into three groups to identify the pros and cons of each option. The group was asked to write their "pros" for each option on warm/orange colored Post-its, and their "cons" on cool/yellow colored Post-its. The groups then rotated around the room until all had a chance to add their pros and cons to each option. The groups could, at each station, reap the benefit of seeing the pros and cons as identified by the group ahead of them.

***Figure 85*** contains Steering Committee member opinions on the pros and cons of each option that were defined by the groups. The group was then asked to rate the options: Outreach efforts and the Buy-in to VHAP option were rated the most highly.

## Figure 85
## Pros and Cons of Selected Health Insurance Expansion Options

| A. Low Cost Coverage Option | |
|---|---|
| **Pros** | **Cons** |
| Employers contribute toward cost | Serious problem if needs catastrophic coverage |
| Relies on private system | State may end up having to pick up the tab for non-covered services |
| Targets employers not currently offering | People don't get care they need |
| Quick to implement | Substitute one kind of care for another (non-covered services) |
| Cost effective | Not based on good medical practice |
| Could get more people in system | No federal $ match |
| No cost shift | Lifetime benefit of $100,000 too low |
| Low cost per person | With information, even employees thought it was yucky |
| Can be time limited for employers that sign up | Creates tiered access to health care |
| | "Cheap" but not for me |
| | Very limited coverage (benefits) |
| | People who can least afford out-of-pocket costs may have to pay larger out-of-pocket costs |
| | Whittles away at gains Vermont has made in access to care |
| **B. Employer Tax Credit Option** | |
| **Pros** | **Cons** |
| Can be time limited for participating employees | Employers buying in small group coverage is expensive |
| Quick Implementation | Need larger subsidy to work |
| Benefit small employer can offer and become more competitive | Does not help firms who already insure employees |
| Supported in focus groups | Gives advantage to new firms |
| Focus group support | No federal $ to match |
| Administratively simple | Unfair to firms currently offering coverage |
| No cost shifted to other entities | Time limited. |
| Cost effective | Sign up may be slow |
| | Didn't work in Kansas |
| | Employers not able to afford initial cash outlay to offer insurance |
| | Too little credit |
| | Unclear if personal financial responsibility enhanced |

| C. Single-Payer Program | |
|---|---|
| **Pros** | **Cons** |
| No cost shifting | Lack of personal financial responsibility |
| Administratively simpler that current system | Decrease in quality |
| Reduced administrative hassle for providers | No clear source of revenue identified |
| Administrative savings at start of program | Appears to be much more costly / now person insured |
| Reduces business HR time spent on health care coverage | Potential ERISA court challenge |
| Payment not barrier to getting necessary care | Difficult to get participation by Medicare |
| Reimbursement same, no payer differences | No focus group support. |
| Everybody in same boat | No quick implementation. |
| More related to ability to pay | Administratively difficult |
| Clearer about where money comes from | Administrative savings disappear after start of program |
| Saves total health care costs | New cost for small business that doesn't offer insurance |
| Covers everyone | Could disrupt existing employment status of private insurers |
| | Provider payments reduced |
| | Lengthy start up |
| | Unlikely chance of enactment |
| | Potential negative impact on business climate |
| | Need to annually adjust tax rates |
| | Significant change for unintended consequences - economic growth - business location or relocation |
| | Increased public bureaucracy |
| | Costs maybe shifted to private coverage |

| D. VHAP Buy-In to Employer Coverage for Eligible Adults | |
|---|---|
| **Pros** | **Cons** |
| Returns "good risk" kids to private insurance market | Difficult to administer need. |
| Covers few people but would save money (a little) to spend on others | Requires a lot of cooperation from businesses |
| Could provide better coverage (benefits) than employer plans | Requires additional outreach to kids |
| Some adult spouses "automatically" added | New administration structure for small # of kids |
| Saves money | Targets very few of uninsured |
| | Private coverage frequently less comprehensive than Dr. D, Medicaid |

| E. Expand VHAP to 300% FPL | |
|---|---|
| **Pros** | **Cons** |
| Targets those most in need of funding | Personal responsibility unclear |
| Gets coverage to population that really needs it | Excludes (1 year wait for those currently insured) many who have worked hardest to take care of themselves) |
| Federal money for parents | Limited Federal money |
| Coverage cheaper than private market. | Will increase taxes |
| Covers more for less | High Cost |
| Builds on existing program | No phase-in tiers for lower income (lower income first) |
| Reduced amount of free care | No identifiable revenue source |
| Administratively more simple than private insurance | Costs may be shifted to private coverage |
| Aggregating purchasing power | |
| Brings in few more people than F | |

| F. Buy- in to VHAP Option | |
|---|---|
| **Pros** | **Cons** |
| Possible to do in an economic downturn | New state admin. Structures required |
| Cost met by premiums | Could provide incentive to maintain low wages in spite of high profit |
| Aggregates purchasing power | Unclear personal financial responsibility |
| Could allow all without coverage to buy cheaper coverage. | No identifiable revenue source |
| Doesn't have to be just those below 300% FPL | Costs may be shifted to private coverage |
| Coverage cheaper than coverage in individual or small group market | Erosion of private insurance market |
| Builds on existing system | |
| Covers fairly high number | |
| Increases competition between public and private sectors | |
| Doesn't require a public revenue source. | |
| Money comes from employers and employees | |
| Makes relative low cost option available | |
| No tax increase | |

| G. Outreach | |
|---|---|
| **Pros** | **Cons** |
| Increases in enrollment will come incrementally | Increased costs |
| Federal match | Provider resistance to expansion of Medicaid eligibles |
| Administratively simple | Upward cost shift |
| Cost effective | |
| Targets already eligible | |
| Meet 97.5% goal for kids | |

Source: Steering Committee affinity chart work.

## F. Rating the Options

When all groups had finished evaluating the options, the pros and cons were reviewed and the facilitator asked for formal recommendations. One option, the Low Cost Insurance option, was readily eliminated for not meeting any of the criteria. The group felt that there was no one option, and perhaps no combination of options when the criteria were considered, that could accomplish the goal of 97.5 percent coverage for children and 95% coverage for adults. The single-payer model would reach the most people, but even that model did not match all the criteria. The group unanimously and strongly agreed that the Low-Cost model should be removed from consideration. The options, as they were grouped and their ratings follow:

- ? 26% Option A: Low Cost Insurance option
- ? 52% Option B: Tax Credits for small firms
- ? 55% Option C: Single-Payer
- ? 55% Option D: VHAP buy in to employer coverage
- ? 55% Option E: VHAP Expansion
- ? 67% Option F: Buy in to VHAP
- ? 83% Option G: Outreach Efforts

Recommendations Made By the Steering Committee:

- ? Think in terms of where we want to progress, don't define in terms of short, mid or long term solutions
- ? Outreach to all
- ? Encourage/foster the direct care models
- ? VHAP Buy-In
- ? Employer Tax Credit
- ? Employer Buy-In to VHAP
- ? VHAP Expansion
- ? Ask federal government to maintain commitment
- ? Federal tax credit for newly insured small groups
- ? Adjust Federal match more equitably for Vermont
- ? Ask Federal government for a drug benefit for Medicare
- ? VT outreach expansion
- ? Remove Low Cost option from consideration
- ? Further analysis of options and related legislation
- ? Identify the options and the problems associated with each
- ? Highlight the pros and cons of the options as bulleted items in report
- ? Address the complexity of making recommendations (both public and private)
- ? Reflect in the report the risks of doing nothing
- ? Discuss Rights vs. Responsibilities (see Schwartz article JAMA May 15, 1991)
- ? Put the Direct Care model in the report and encourage its "flourishment"
- ? Report should reference BISHCA results to help us narrow the challenge (about 39 percent of the uninsured are eligible, but not enrolled)

## SECTION SIX: LESSONS LEARNED AND RECOMMENDATIONS TO STATES

A major feature of the Vermont State Planning Grant was its emphasis on data collection. The project included a survey of households in Vermont, which provided detailed quantitative information on coverage levels across various socioeconomic groups. These data were vital in targeting eligibility under the various policy options and in estimating the cost of potential coverage expansions. The project also included a series of focus groups and expert interviews that provided guidance on how the various policy options could be tailored to best meet the needs of Vermonters.

The pace of the project was so fast that many of the lessons from this exercise probably are not yet recognized. However, the major lessons learned from this process are discussed below.

### A. Importance of State Level Data

The quantitative data developed for this project was vital to the decision-making process for the Steering Committee. The data enabled us to identify the groups most in need and provided a basis for estimating the cost of various policy options. Members of the steering committee have remarked about the importance of this information. Some specific observations include:

? The Steering Committee believes that the state is unique. Using state level data reassured the group that this was adequately reflected in the development and evaluation of options.

? The data analysis showed that about 39 percent of uninsured people in the state are actually eligible for VHAP but have not enrolled. This greatly affected the group's views on what is needed in the state.

? These data also showed that, because VHAP already covers adults at comparatively high income levels (i.e., 185 percent of the FPL for parents and 150 percent of the FPL for non-custodial adults) any further expansions in eligibility for subsidized coverage would need to focus on near-poor and lower middle-income groups.

The qualitative data collected through the focus groups was less compelling than the quantitative data. However, it was useful in identifying stakeholder interests. Two important design issues were highlighted through the qualitative process including:

? Eligibility for employer-based subsidies such as an employer tax credit should not be limited to only those firms that do not offer coverage. Insuring firms should also benefit.

? Uninsured people seemed to favor the idea of employer tax credits to provide coverage to workers more than a direct subsidy to lower middle-income people to purchase non-group coverage. This appears to reflect a public preference for employer-sponsored coverage.

### B. Cost Effectiveness of Quantitative vs. Qualitative Data

The quantitative data appeared to have a greater impact on the process than the focus group and interview data. In particular, the quantitative data was important to the cost analysis of policy

options, which was quite important to process. However, both the quantitative and the qualitative data were necessary to assure that the policy options addressed the areas of greatest need. Moreover, it helped identify approaches that would receive support from employers and the public in general.

The qualitative data was probably more important than generally recognized. Lewin concluded that one needs both approaches for a successful process, although it is possible that another state with more limited funds could address some of these needs with a less extensive data collection effort.

## C. Data Collection Activities Not Pursued

The state collected most of the data that they had originally planned to collect through the household survey and the focus groups. However, the state did decide against doing a survey of employers primarily because of cost and the length of time required to do the survey. It was felt that the employer focus groups and interviews would be a sufficient representation of the employer community. The lack of Vermont-specific employer survey data did not emerge as a problem during the course of the project.

## D. Strategies to Improve Data Collection

It is important to take advantage of the experience that states have had in conducting surveys of households concerning health insurance coverage. A number of states have conducted similar surveys and have amassed a great deal of experience that is available to other states wishing to do a survey. The data analysis experts at BISCHA found it helpful to review the questionnaires and survey techniques used in prior studies to improve the data collection effort and to avoid making similar mistakes.

Information of this type is available from the State Health Access Data Assistance Center (SHADAC). They can provide draft survey instruments and can help in survey design. The center can also assist states in designing survey procurements. This information was very useful in designing the Vermont survey. It provided some verification questions that recently have been added to existing surveys of health coverage, which have a significant impact on coverage estimates.

This is also a good source of information to use in determining sample size. This is very important to assuring that interested parties will have reasonable expectations of what the data will show. For example, sample size will greatly affect the extent to which results can be disaggregated by demographic group or by sub-state geographic regions.

## E. Additional Data Collection Needs

There are five areas where additional data collection could be useful. First, the Vermont Commission on the Public's Values and Priorities will be conducting a survey to better understand the public's views on health care and health insurance coverage. Questions of this type were not included in the household survey conducted under the grant. Second, targeted

over-sampling of high-risk groups could provide a clearer picture of coverage issues for these groups. Third, information on the "value" that the uninsured place on health care and health coverage could have been helpful. Fourth, better information is needed on what employers expect from competition among insurers.

Fifth, the existing data do not provide the information needed to estimate the size of or properly identify the "underinsured" population. In many analyses, the underinsured are defined to be those experiencing out-of-pocket expenses in excess of a given percentage of income such as 5 or 10 percent. In other studies, the underinsured are defined to include people in health plans with only minimal coverage, regardless of whether they actually experience high out-of-pocket expenses.

Both of these definitions require extensive data on out-of-pocket health spending and the coverage characteristics of their health plans. The issue of how to identify and address coverage for the underinsured was raised during Steering Committee deliberations, but remains unresolved. However, the lack of this information does not seem to have significantly impeded the process.

## F. Organizational or Operational Lessons Learned

The analyses performed under this grant could lead to additional outreach activities for enrollment in Medicaid, VHAP and/or the Dr. Dynasaur program. As discussed above, the household survey and data analyses indicated that 39 percent of all uninsured people in Vermont are eligible for state programs but have not enrolled.

This suggests that a substantial portion of the uninsured problem in the state could be addressed with expanded outreach efforts for children in particular. Moreover, under the current federal matching rates (63 percent regular Medicaid, 73 percent SCHIP), most of the cost of these coverage expansions could be paid for by the federal government. However, it is unclear what outreach methods would be most effective.

Another lesson from the process is the importance of access to direct services for people who do not have insurance. As discussed above, a number of hospitals in Vermont and New Hampshire have established direct care programs for uninsured people encountered in nursing rooms, with particular emphasis on those with chronic conditions. These individuals are given regular appointments with physicians in hospital owned physician practices to provide preventive care for people with chronic illnesses. The hospitals with these programs believe that these programs have greatly reduced emergency room visits. The state could take steps to encourage this approach throughout the state.

One of the key lessons learned about insurers in Vermont is some of the dynamics of competition in the industry. It became clear in this study that for insurers to offer coverage at competitive prices, there must also be substantial competition among providers. The reason for this is that insurers typically negotiate volume discounts and selective contracting arrangements with providers competing on the basis of price so that insurers can offer coverage at competitive rates.

However, selective contracting is ineffective in a market where there are few competing providers, as is the case in Vermont. For example, 12 of the 14 hospitals operating in Vermont are the only hospital within 30 miles, which effectively gives them a monopoly in the local health care market. Thus, without competition among providers, it is difficult for insurers to negotiate the agreements with providers that they need to offer coverage at more competitive prices. This finding had significant implications for the potential for increased competition in Vermont insurance markets.

The Steering Committee's interactions with the employer community were quite successful. The Steering Committee itself included representatives of two organizations representing businesses in the state. These include the Vermont Chamber of Commerce and the Vermont Business Roundtable. In addition, Lewin conducted focus groups with employers to help in defining the problems in the state, followed by a second round of focus groups to obtain employer views on suggested policy options. The process probably would have proceeded much less smoothly if the employers had not had such involvement.

## G. Recommendations to Other States

As discussed above, states should take advantage of the information available from other states that have conducted similar surveys and financial analyses of health reform options. These activities can be very complex and difficult to attempt. It is important to take advantage of what was learned in these activities to avoid "reinventing the wheel" in survey design and policy analyses.

Towards the end of the project, the state engaged an independent health care expert to facilitate the Steering Committee's final meeting in which policy recommendations were selected. Introducing a fresh face at that point in the process appeared to re-energize the group and made it easier to sort through all of the various reports and policy options analyzed during the project.

Covering the last 5 to 10 percent of the population will be complex and difficult. It will also be complicated by the conflicting priorities of various stakeholders in the system. Some of these competing goals include:

? Universal access with a strong private insurance market;

? Universal access at low cost, while maintaining high quality;

? Government programs for certain groups without causing "crowd out" in the private market;

? Broad based, comprehensive coverage for everyone, but without a "single-payer" system; and

? Differing views on the role of Government.

## SECTION SEVEN: FEDERAL RECOMMENDATIONS

The Steering Committee made the following recommendations to the federal government.

### A. Maintain Existing Commitment of Federal Participation in 1115a Waivers that have Achieved Coverage Expansions

The Vermont Health Access Plan (VHAP) is currently operating under an 1115a Medicaid Research and Demonstration Waiver approved by the federal government in 1995. At some point in the near future, the existing waiver will need to be renewed. The success of this waiver initiative, and similar waiver initiatives in other states, is dependent on the state having sufficient state and federal resources to maintain these coverage commitments. It is recommended that the federal government (CMS) grant permanency to 1115a expansion populations by considering them part of the Medicaid spending base at the point of consideration of a new waiver, thereby eliminating the need to fund their coverage through savings under the budget neutrality provision of the 1115a waiver program. Granting permanency to these expansion populations will offer the states the best opportunity for having a sustainable program.

### B. The Federal Government Should Create Additional Tax Incentives Directed at Small Employers to Encourage the Provision of Health Insurance

The most recent survey of the uninsured, as have the two other surveys done in Vermont in the 1990's, underscores that small employers are much less likely to offer health insurance than large employers. The Steering Committee recommends that the federal government use its tax authority to provide incentives to small businesses to cover their employees. An approach to expanding coverage considered by the Steering Committee was to provide subsidies directly to employers to help them provide coverage to their workers. This could be accomplished through a refundable tax credit to employers who are not now providing coverage. Existing proposals for an employer tax credit would set the amount of the tax credit equal to a percentage of the employer's expenditures for employee health benefits (e.g., 25 to 40 percent).

### C. Congress Should Establish a Medicare Drug Benefit

Vermont first addressed prescription coverage for low income Medicare population in 1989 through the creation of VScript, a state funded maintenance drug program for elderly or disabled Vermonters not eligible for coverage under Medicaid. As part of the implementation of the 1115a Medicaid waiver approved by the federal government in 1995, drug coverage was expanded. Additional drug coverage is also being provided under a state-only program. Other states have similarly established state programs to provide this essential coverage. Modernization of Medicare through the creation of a drug benefit would potentially make state resources available to either maintain existing initiatives for the uninsured or finance some of the coverage options identified by the Steering Committee.

# State of Vermont

# Expansion of Health Insurance Coverage to Uninsured Vermonters

***Interim Final Report - REVISED***
**APPENDICES**

**HRSA State Planning Grant**
**Report to the Secretary**

***October 29, 2001***

## The Vermont Agency of Human Services

**with assistance from:**
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# Appendix A:
# Insurer Workgroup Report

# Insurer Workgroup Report

**Client:**
**Office of Vermont Health Access**

***May 21, 2001***

**Prepared by:**
**The Lewin Group**

## INTRODUCTION

One of the tasks under the HRSA State Planning Grant is to elicit the insurer/health plan perspective on identifying barriers to coverage for the uninsured. Representatives from three insurers operating in Vermont participated in the Insurer Workgroup on March 8th from 12:00 p.m. to 2:00 p.m. at Action Research, Inc. A list of invited participants is found in **Appendix A**. The purpose of the meeting was to discuss factors affecting health insurance premiums and coverage in the state and means of expanding health insurance coverage in Vermont. The protocol used in leading the discussion is provided in **Appendix B.**

The material presented here is intended to be a summary of the views expressed by the participants. As such, it does not represent the views of the Lewin group or the state of Vermont.

## EFFECT OF STATE MANDATED BENEFITS

Participants felt that it was not possible to predict the impact of mandated benefits on coverage other than general research findings that increasing premiums decrease coverage rates. Insurers have found that coverage mandates increase premiums.

? One insurer indicated that he had data showing that mandatory benefits (e.g., chiropractic and mental health, including the requirement that insurers offering mental health coverage must go through mental health agent licensing) have increased insurance premiums in the state by 5 to 10 percent.

? Mental health parity has had a big financial impact and makes up a larger part of health care costs in Vermont than in most other states (outside of New England).

## EFFECT OF COMMUNITY RATING

Workgroup participants stressed that community rating has not, on its own, affected average premium levels. However, premiums for younger groups generally increased after implementation of community rating while premiums for older groups decreased.

? Some small groups with relatively healthy (i.e. low cost) workers escape the community rated premium by establishing a self-funded insurance product supplemented with reinsurance to cover high-cost cases. This typically leaves only higher cost cases in the community-rated risk pool, resulting in higher premiums. One participant said that "selection behavior" has "polluted" the community rated risk pool in Vermont.

? Community rating has helped to "level the playing field" for Blue Cross Blue Shield (BCBS) and the HMOs because prior to this legislation, BCBS and HMOs were the only health plans required to community rate. Leveling the playing field caused some carriers to think about leaving the state, because once community rating was established, the most desirable target groups weren't as easily accessible. However, this alone did not cause them to leave the state.

? Participants asserted that the pre-community rating market was in worse shape than the current market. Doing away with community rating would have a destabilizing effect on the market, especially the small group market.

? There was general agreement that community rating is positive for the state.

## REASONS FOR SMALL NUMBER OF INSURERS IN VERMONT MARKET

The participants agreed that there is no one reason for the small number of insurers operating in Vermont. Rather, it is a combination of regulatory and market issues.

? The decline in the number of insurers in the state reflects a nationwide trend of consolidations in the insurance industry and a general reduction in the number of insurers who are interested in staying in the business of health insurance.

? One insurer reported the generally held belief among the insurance industry in Vermont that for some carriers, Vermont is such a small market that it is not worth the effort or expense to comply with the full range of state regulations. State regulations mentioned include community rating, mental health parity (including the requirement that insurers offering mental health coverage must go through mental health agent licensing) and loss ratio limits. One insurer stated that if it were not for an existing office in the state, that insurer would not be operating in Vermont.

? Entering a highly regulated market for a relatively small number of covered lives is not attractive to most insurers.

? Those companies who were not skilled at actually managing care left the state when they were no longer able to profit from risk selection (i.e. marketing coverage to only lower cost groups).

? Lack of competition among providers makes it difficult to form effective networks. Insurers that enter the Vermont market must be prepared to compete with existing managed care plans (TDHP and MVP) as well as offer other products, "[it's not possible] to come in and pull off just one market segment".

? One participant said that Vermont's aggressive regulatory environment (including community rating, loss ratio limits, mental health parity) has kept large transnational insurance/managed care companies that do business in Maine from entering Vermont.

? Talk of a single payer system makes insurers uneasy about investing in Vermont.

## IMPACT OF SMALL NUMBER OF INSURERS ON VERMONT MARKET

Participants argued that creating competition through more insurers is not the answer to better cost control. This is due to the fact that insurance costs are driven primarily by utilization which

is difficult to control in a market with few competing providers (i.e., cost control through selective contracting, etc.).

? There was general consensus that with the exception of Kaiser Permanente, those insurers that left the state were not the "major players". In fact, the departure of these insurers has made the market more financially stable.

? One insurer stated that it would be risky to attract a large insurer with substantial capital backing and the ability to artificially reduce prices in the short term. Insurers in the state currently are not prepared to compete in this way and could be driven out of business.

? Alternatively, one insurer pointed out that the cost structure of a new entrant to the insurance marketplace would be worse than that of an existing carrier due to their lack of volume. For this reason, new entrants would not necessarily reduce premiums.

? Insurers do not have leverage to force competition among providers, hospitals and clinicians. This makes it difficult to compete on the basis of controlling costs through effective provider networks.

## COMPETITION IN THE DELIVERY SYSTEM

Participants agreed that hospitals are not as "neat and clean" as they should be or have been made to be in other parts of the country. While not all participants agreed that there are too many hospitals in the state, there was agreement that existing hospitals could operate more efficiently. Also, there was consensus that hospital inefficiency is due to a lack of competition among providers. Competition is minimal because each hospital is the only hospital within many miles. Thus, insurers believe that they do not have the leverage to effect competition among providers.

? The centers of excellence model whereby hospitals develop expertise due to large volume of patients is not taking hold in Vermont. System formation has been affected by the promise that local hospitals will not be eclipsed by larger tertiary hospitals, so that hospital services will be available within most communities. Vermont providers are very committed to community-based care.

? The two systems which have formed in the state (Fletcher Allen and Dartmouth Hitchcock) did not form through "true consolidations and mergers...what's happened is they have affiliated, integrated and haven't changed a whole lot. They're protecting themselves...it's a contracting strategy". Another participant concurred that the alliances and affiliations in Vermont are "protective rather than accelerating [the] consolidation of services".

? Insurers would like to realize some of the gains that they "would hope would be attributed to an integrated community tertiary base system of care" and would be willing to work with these hospital systems to realize cost savings.

? One participant stated that the Dartmouth-Hitchcock and Fletcher Allen systems, along with 2-3 other hospitals, could cover the inpatient service needs in the state alongside a system of urgent and emergency care facilities.

? Another participant suggested that having two medical schools in Northern New England may be too many. However, there also seems to be support for the proposed expansion at Fletcher Allen.

? Insurers would like to have the ability to vary premiums by geographic area. They argued that this would encourage cost control by providing purchasers with information on the cost of providing care in their area.

? The insurers reported that it is not the hospital *systems* in Vermont which are the high cost entities but rather the small, rural hospitals.

## TRI-STATE REGULATORY MODEL

The idea of creating a tri-state (Vermont, New Hampshire, Maine) regional insurance authority was brought up with Workgroup participants. The authority would take care of insurance rate approvals, guaranteed issue rules and rule standardization, effectively standardizing regulatory compliance across the tri-state area.

? The participants indicated that this might increase the number of carriers operating in Vermont but said that they do not believe that this increase in competition would decrease premiums because there would still be little competition among providers.

? The tri-state regulatory model would affect only those fully-insured firms that are subject to the community rating regulations (i.e., firms with 50 or fewer members).

## IMPACT OF COST-SHIFTING

There was a general consensus that in response to underpayment in Medicaid and Medicare, hospitals have generally shifted costs to private payers in the form of higher charges. This was cited as a major reason for higher private insurance premiums in Vermont rather than in other parts of New England including various urban centers.

? Premiums are reported to be higher in Vermont than in some major cities, primarily due to the cost shift. One participant indicated that the premium for a given health plan in Bennington, Vermont is about 22 percent greater than it is in Glens Falls, New York (located about one hour from the Vermont border).

? Cost-shifting is a major reason for premium increases.

? When payments are averaged across all payers in the state, per capita health care costs in Vermont are generally lower than in other states. What this average masks, however, is a sharp difference in payment levels for public programs and commercial insurers. Public

program payments for health services in Vermont are substantially lower than in other states, which causes Vermont providers to shift a greater proportion of costs to commercial insurers than in other states. Consequently, per capita costs for commercially insured persons in Vermont are substantially higher than in many other states where there is less cost shifting, even though overall average costs in the state comparatively low.

? There was general consensus that increased Medicaid/Medicare payment rates would result in decreased commercial rates. One participant remarked however, that, "it does take a leap of faith that the hospitals just won't pocket the money". The participant suggested that a "structure" is needed (such as the state's hospital budgeting system) to prevent this from happening.

## CONTROLLING UTILIZATION AND COSTS

Participants generally agreed that changing provider behavior and utilization is the key to cost control.

? Disease management has been found to be an effective means of controlling beneficiary utilization. The focus for reducing costs in the long term is to influence utilization decisions by providers using: financial incentives (such as "risk sharing"), providing comparison and best practice information, sharing data, disease management strategies, small process interventions, and developing good working relationships with providers.

? One participant mentioned that the number of hospitals in the state should not be the main focus of health planning efforts. Instead, the state should focus on a health planning model for the whole delivery system.

## BARRIERS TO ACCESS FOR THE UNINSURED

Participants cited several reasons why some people do not buy health insurance coverage: (1) cost, (2) lack of "need", it may be wiser to pay out-of-pocket when a healthcare need does arise, and (3) it does not cover alternative therapies.

? Their experience has been that high deductible packages are not necessarily popular with employers. Employers are interested in plans that provide reasonable deductibles, reasonable co-pays, comprehensive network access, and comprehensive coverage in general.

? One insurer stated that a combination of strategies is required to extend insurance to the last 10 percent of uninsured in Vermont. The same participant believes that a new insurance product with a "25 percent discount" (refers to a combination of lower rates and reduced coverage), for example, could encourage some Vermonters to buy their own coverage: "[the percent uninsured] might only [go down] a percent or two in the state but that to me is part of the solution...I don't see any silver bullet".

? Encouraging people to sign up for Medicaid could cause some privately insured persons to substitute public for private coverage (i.e. crowd-out) which would disenfranchise other people and possibly result in the loss of coverage for some persons.

? There is a perception that "if you are hurt, you're going to be taken care of and if you can't work anymore, you'll be on Medicare/Medicaid".

? One insurer indicated that unless required to do so, the last 10 percent of the uninsured may not opt for insurance coverage, even at discounted prices.

## INSURERS' RECOMMENDATIONS TO THE STATE

Throughout the Workgroup discussion, the following suggestions were made:

? Allow for regional ratings differentials such that insurers can pass on savings in certain communities to employers (and therefore employees), thereby encouraging changes in provider practice. An insurer reported that there can be as much as a 25 to 30 percent cost differential (for provision of healthcare services) between certain zip codes in the state. Instead of instituting regional ratings at the zip code level, it was suggested that five regions be developed for this purpose.

? Collect and distribute utilization and outcomes information for individual hospital services areas throughout the state to foster quality improvements, reduce practice patterns variation, and encourage more competition among providers.

? Maintain hospital oversight, however, restructure the process. Regulate hospital budgets on an annual basis is not productive and the framework the state is using is outdated. Instead, the state should be proactive about planning for the future of the healthcare system as a whole five years from now, including both inpatient and outpatient services.

? The State should focus on the planning of health systems (including major sources of outpatient revenue) rather than just hospitals. One participant however, questioned the usefulness of expanding the "less than perfect process [that is currently] in place for hospitals." All agreed that a wider mix of measures is necessary to "reflect the diversity in the systems that are regulated."

? Develop better tools (data) to effectively negotiate spending levels with providers. They asserted that the current State program for hospital budget review does not have the resources to match what the hospitals are capable of devoting to the regulatory process.

? Capitalize on affiliations/hospital integration already in place through the Fletcher Allen and Dartmouth Hitchcock systems and try to bring about true consolidations and mergers for realization of economies of scale.

? Involve stakeholders (other than hospitals) in hospital/system strategy, planning and regulation.

## APPENDIX A: INSURER WORKGROUP PARTICIPANTS

HRSA State Planning Grant
Insurer Workgroup Participant List

| | | |
|---|---|---|
| Donald George | Thomas Scull | Jim Hester |
| Vice President of Managed Healthcare | Senior Account Executive | Vice President |
| Blue Cross/Blue Shield of Vermont | CIGNA | Mohawk Valley Health Plan |
| PO Box 186 | PO Box 367 | 66 Knight Lane, Suite 10 |
| Montpelier, VT 05601 | Burlington, VT 05402 | Williston, VT 05495 |

## APPENDIX B: INSURER WORKGROUP PROTOCOL

? What has been the effect of state mandated benefits on premiums and the number of persons with coverage (chiropractic, mental health, maternity etc.)?

? How has community rating affected your business? Has it raised premiums? Has it increased or decreased coverage?

? In your opinion, has community rating caused insurers to leave the state? Why have you stayed?

? Would you advise any revisions of the existing guaranteed issue and community rating laws? What would be the effect on high premiums by age and health status? Would this reduce or increase the number of persons with health insurance?

? Is community rating in the small group market (50 or fewer lives) being undermined by groups who escape the community rated pool by self-insuring? Is community rating being undermined by the use of association health plans?

? What is the minimum number of lives for your plan to be viable? Do you define service areas in terms of state boundaries or regional markets?

? How can managed care work in a predominantly rural state such as Vermont? Is there enough competition among providers to make selective contracting viable? Are there effective financial incentive models that can be used with provider networks (i.e., risk sharing, capitation etc.)?

? What can be done to expand coverage? Would a high risk pool lead to increased coverage? Would it attract more insurers to the state? If it were funded with an assessment on all insurance?

? Could a low cost package be developed for Vermont that would lead more employers to offer coverage? Have employers been asking for such an option?

? Would it be to an advantage to introduce a program that permits small firms who are not currently providing coverage to purchase a basic benefits package that is free of state mandated benefits? In your experience, would employers buy such a package?

? What would be the effect of subsidizing the basic benefits package for employers who are not now offering coverage? (New York has established a similar program using a reinsurance program funded with Tobacco settlement funds).

? What proportion of premiums is attributed to the cost-shift and how has this affected costs and the number of persons with coverage?

? If public program payment levels were increased would providers lower their private payer rates or would they retain the increase as a windfall? Could the state hospital budgeting process be used to preclude providers from retaining such a windfall? Would this be necessary?

? Would a program that standardizes insurance regulation across the three-state region of Vermont, New Hampshire and Maine make it more attractive for insurers to operate throughout this region?

? Do you have any other ideas on how coverage could be expanded in Vermont?

# Appendix B:
# Provider Workgroup Meeting Summary

# Provider Workgroup Meeting Summary

**Client:**
**Office of Vermont Health Access**

***May 21, 2001***

**Prepared by:**
**The Lewin Group, Inc.**

## INTRODUCTION

An important component of the HRSA State Planning Grant is to elicit public and private sector clinical representatives' opinions on quality, access and health outcomes related to proposed health coverage and program design options under consideration. The purpose of the meeting held at Vermont Technical College March 26th from 6:30 p.m. to 8:30 p.m. was to begin the dialogue with providers to obtain their perspectives and suggestions. Both administrators and direct care providers took part in the meeting. A list of participants, including two who were unable to attend the meeting and were interviewed separately, is included in **Appendix A**. The agenda and protocol used to lead the discussion are presented in **Appendix B**.

Although the original intent was to consider the appropriate use of resources, utilization and health outcomes *outside of restrictive economic considerations*, a major theme throughout the meeting was the need to update Medicaid reimbursement levels.

## SUGGESTED CHANGES TO THE HEALTH CARE SYSTEM

Along with general introductions, each participant was asked to mention one aspect of the healthcare system they would most like to change. Following are the responses, in no particular order:

? Overcome fear of involving the community in the discussion of the uninsured and access to healthcare.

? Pay providers (clinicians, hospitals, not-for-profit health centers and dentists) fairly for what they do, recognizing that Vermont's low reimbursement rates are of great concern to providers.

? Establish universal coverage (especially considering the size of the state).

? Take inventory of successful community healthcare systems and model change after what has been shown to work.

? Support a single clearinghouse for quality in health care.

? Eliminate pre-authorization (as Aetna did and saved $32 million); "unmanage" healthcare.

? Be able to put the Free Clinics "out of business," having achieved universal access to health care services.

? Heavily tax direct-to-consumer pharmaceutical marketing/advertising and other non-essential health services as these are often the drivers of healthcare inflation.

? Reimburse hospitals for community outreach.

## HEALTH OUTCOMES

Healthy Vermonters 2010 goals (**Appendix C**) were used as a starting point for discussing health outcomes pertinent to designing a health benefits package for the uninsured.

? Access by the uninsured and underinsured to primary and preventive health care services, specifically mental health and dental health, was identified as crucial to improving health outcomes. One participant cited Vermont Free Clinic data in listing the most common reasons for free clinic visits: mental health, including anxiety and depression; diabetes; hypertension; high cholesterol; and repetitive injury stress such as back and joint pain. Each of these can be chronic conditions which could result in significant healthcare expenditures if not monitored and addressed through primary and preventive healthcare, "the uninsured need a healthcare home".

? Obesity is considered a risk factor associated with many serious and chronic health conditions. Reducing the overall rate of obesity is seen as a means of improving health outcomes through a reduction in morbidity.

? Successful healthcare reform at the macro level (i.e. through legislation and regulation) is dependent upon micro level change. Encouraging personal accountability for health decisions is the foundation of micro level health reform. Two participants expressed that coalition-building between the Department of Health and providers is key to improving the health of Vermonters.

## ACCESS TO HEALTHCARE SERVICES

The discussion of prioritizing various health outcomes was imbedded within a broader discussion of reduced access, in part due to provider shortages.

? The point that access to healthcare is not the same as insurance coverage was made. Insurance coverage does not guarantee access, and may not be the best vehicle to improve continuity of care. Some participants were in favor of establishing universal coverage through a single payer system but there was not consensus on this issue. However, there was consensus around establishing universal *coverage.*

? Provider shortages in certain specialty areas are likely to broaden due to inadequate compensation. Disparities in access already exist within specialty areas (the community mental health system sees 10-12% uninsured patients, compared to the state's average mental health providers see who 7-8% uninsured patients.)

? Several participants expressed the importance of utilizing private sector solutions to address the issue of the uninsured before expanding the public sector. That is, before earmarking funds for safety-net healthcare provision systems (such as Free Clinics and community health centers) operating in parallel to "traditional" providers such as hospitals and individual provider practices, it is important to exhaust resources available in the traditional sector. This could include improving reimbursement rates in Vermont.

? Participants cited a need for more mental health providers. Vermont currently has few child psychologists, with sufficient demand to employ many more.[1] Demand for dental services also outstrips capacity. There are eight pediatric dentists in Vermont. This is probably not a sustainable number. Older dentists are retiring at a rate faster than new dentists are opening practices. Some may leave the state due to a perception of unfair compensation practices.

? There is concern that insufficient resources will be expected to serve an increased demand if Medicaid coverage is expanded. Participants agreed that the state should focus on current Medicaid enrollees and prioritize among services.

? A participant stated that "negligence towards preventive healthcare for the uninsured and underinsured" exists in Vermont.

? It was suggested that the state research the health education and services currently being provided in Vermont schools. (For example: child psychiatry, dental and ophthalmology.) Capitalize on the ability to reach children (and their parents) and do not duplicate efforts/services.

? One participant mentioned a study in which elderly people with good preventive care were found to die later but more quickly than those without access to preventive care, suggesting preventive care does minimize the need for extensive end-of-life nursing care.

## COORDINATION IN PROVISION OF HEALTH CARE

When asked if there is a way to characterize the statewide "safety net", most participants agreed that there is no single coordinated statewide effort.

? "We have safety net provisions but we don't have a statewide response. That's what's lacking. We haven't articulated what a safety net needs to be in terms of insurance coverage, access to providers, location of providers, support for providers. It would be great to have a statewide response."

? One provider described how the disjointed structure created by the lack of a statewide safety net affects the daily work of providers: "It's distracting...you end up doing the best you can do. We're missing a step [in terms of] implementing the best medicine [and] practices in treating patients."

? One participant said the "safety net [in Vermont] is superb...Vermonters have excellent hospital care". However, the same participant acknowledged that access to primary care is a problem in certain areas.

[1] According to the 1998 Survey Report: Health Care Professional Profiles, published by the Department of Health in December, 2000, there are an average of two child psychiatrists per 100,000 population compared to the suggested average of 13 per 100,000.

? Participants concurred on the need to identify effective models of affordable, accessible care that currently exist to determine if they are replicable and sustainable in other parts of the state.

## QUALITY IN HEALTHCARE DELIVERY

A consequence of providers being stretched to capacity could be a diminishment in the quality of care provided. Additionally, participants fear that providers will be driven out of the state if the number of patients receiving state medical assistance increases and reimbursement rates do not.

? There was general consensus that the state should pay providers fairly for the services they are currently providing.

? One participant suggested that patients should share in the cost savings involved in making decisions about where to seek care, from what type of providers, what brand of medication to prescribe/purchase, etc. Under such a system, providers and patients would work together to insure cost effective quality care. Also, there should be a mechanism for full disclosure on providers' number of operations, outcomes, credentials and costs such that purchasers of healthcare and patients can make the most informed decisions possible.

? Participants agreed that providers are looking for some level of intellectual or educational support. The academic "detailing" provided by the Vermont Child Health Improvement Program (VCHIP) on pediatric preventive services was cited as an example. In addition to VCHIP, the Vermont Program for Quality in Health Care (VPQHC), and AHEC programs also function in a small learning group capacity. According to providers, improvement in the system must be tied to improving the quality of care.

? When asked if there is a difference in the quality of care uninsured people receive, participants agreed that while there shouldn't be, there *is* often a disparity. For example, it may not be possible to follow prescribed drug formularies in caring for an uninsured person, due to the expense of the drug.

## BENEFITS DESIGN

In an exercise designed to prioritize current services offered through VHAP, participants were asked to choose four services (see **Appendix D** for complete list) that they would **not** include in an insurance program for the uninsured. This exercise was very difficult for participants, and was described as "painful".

? Participants chose to remove chiropractic services and provision of orthotics, organ transplants, and transportation services from the covered service list. All agreed, however, that eliminating these services would probably have only a marginal effect on cost.

? One participant said it shouldn't be an exercise in *completely* eliminating services. Example: dental coverage should not be cut across the board but only certain dental services could be included in a benefits package for adults (services to manage pain and infection) while children would receive comprehensive care.

## REIMBURSEMENT

There was general agreement that Medicaid reimbursement is insufficient. "We may be able to say that we have the highest insurance coverage rate in the nation but if there aren't any providers to take those patients, we won't have accomplished our goal."

? Currently, dental providers are reimbursed 60-70 percent of the cost of providing care. This is about the same cost as the national average for overhead in dental practices (between 65 and 70 percent). Providers were asked to consider whether there should there be differential rates within the Medicaid reimbursement system to further compensate providers who accept a larger caseload of Medicaid/uninsured patients. Reaction was mixed about this issue.

? Comparatively, several participants noted that physicians are reimbursed about 40 percent of their charges, asserting that it is not a sound business practice to try and make up cost with volume.

? Providing services to patients without insurance does not necessarily entail lack of compensation. A provider described extending the same discount provided to Blue Cross Blue Shield-insured patients to uninsured patients. Payment plans designed to allow patients to make regular installments over time are often devised as well.

? The amount of money being spent on alternative health therapies such as herbals, massage and chiropractic care is increasing while reimbursement for "traditional medicine" is less than the cost of providing it (in the Medicaid program).

## RECOMMENDATIONS

? Design Medicaid benefits programs such that they do not provide disincentives to providers participation. One participant said, "If the state paid cost for Medicaid, it would find more providers, especially dentists, willing to care for the uninsured".

? Both the reimbursement structure and the actual functioning of the Medicaid system need to be addressed in order to effectively extend insurance coverage to more Vermonters. The state should consider addressing the feasibility of obtaining direct healthcare services for uninsured persons.

? Continue to support the historic and effective public/private partnership between the state government and health care providers (such as that between the Department of Health and primary care providers which has been a major factor in Vermont's leading child immunization rates).

? Look at community-based systems of health care delivery that are working to provide good quality care, in a cost-effective way while providing equal access to benefits.

## *APPENDIX A: PROVIDER WORKGROUP PARTICIPANTS*

HRSA State Planning Grant
Provider Workgroup Participant List
March 26, 2001

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## *APPENDIX B: PROVIDER WORKGROUP AGENDA*

**6:30 Introductions/Overview**

**6:50 Dinner served**

**7:00 Working meeting begins - Prioritize Desired Health Outcomes Measures**

(1) Prioritize *Healthy Vermonters 2010* goals. (see sheet provided)
(2) What current deficits in public and private health insurance coverage prevent attainment of major health goals?
(3) What current resources could be redirected through benefit design to advance *Healthy Vermonters 2010* initiatives?

**7:20 - Identify Barriers to Healthcare Access**
(1) Discuss the adequacy of statewide hospital/clinician "safety net" response to coverage of uninsured healthcare services. What, in your opinion, represent barriers to care for the uninsured?
(2) How do you currently deal with care of the uninsured? How is it dealt with financially (on the books)?
(3) How would you describe the quality of care for uninsured patients?
(4) How do administrative burdens affect your ability to effectively administer care to the uninsured?

**7:45 - Assess Benefits Packages**
(1) What specific services are most commonly provided to uninsured patients?
(2) What benefits should be included in a benefits package for the uninsured? (see sheet of OVHA programs' benefits)
(3) What services are currently needed, but often not provided to uninsured patients due to financial and structural barriers in the system?

**8:00 - Provider Issues**
(1) Are the payment rates under Medicaid sufficient?
(2) How does cost-shifting work?
(3) Should different rates be used for a new program to cover the uninsured?
(4) Would there be enough providers to meet the demand for care by an influx of newly insured persons?
(5) Are there ways to improve coordination among safety-net providers? Ways to reduce administrative burden?
(6) What are the pressures on providers serving Medicaid patients?

**8:20 - Towards Reform**
(1) How does the provider community of Vermont view the viability/importance of expanded health insurance?
(2) What public/private entities should be responsible for insuring the last 10 percent of uninsured Vermonters?

**8:30 Conclusion**

## *APPENDIX C: HEALTHY VERMONTERS 2010*

Published in September, 2000 by the Vermont Department of Health and Agency of Human Services, ***Healthy Vermonters 2010*** provides a framework for continuing to improve the health of Vermonters. Generally, this set of public health goals seeks to increase the quality and years of healthy life for Vermont citizens, eliminate health disparities among different groups in the population and improve access to care. The specific Objectives in Health Outcomes are tied to broad Objectives in Improving Access (each listed below). This framework was developed through a process of workgroups and interviews involving hundreds of Vermont citizens and many organizations. You may have participated. The publication is located on the side table if you are interested in looking at it. Also, it can be accessed online at the state's ***Healthy Vermonters 2010*** website: www.state.vt.us/health.

***Healthy Vermonters 2010*** builds upon the goals previously set in ***Healthy Vermonters 2000***. It has been reported that the State made progress toward two-thirds of the goals established in ***Healthy Vermonters 2000***, including meeting some objectives. ***Healthy Vermonters 2010*** contains current population statistics and details goals to be met based on these statistics. Below is a broad summary of the Objectives in Improving Access and Health Outcomes found in ***Healthy Vermonters 2010*** for purposes of our discussion.

### *Healthy Vermonters 2010* Objectives in Improving Access:

1. Improve Access to Primary/Preventive Care
2. Improve Number of People with Health Insurance Coverage
3. Increase Health Counseling
4. Reduce Hospitalization Rates (for pediatric asthma, diabetes, pneumonia/influenza)
5. Improve Health Education in Schools

### *Healthy Vermonters 2010* Objectives in Health Outcomes:

1. Reduce Drug and Alcohol Abuse (adolescent and adult)
2. Improve treatment, counseling and support of people with arthritis, osteoporosis and, other disabilities.
3. Improve cancer screening and education (especially colorectal, breast, cervical, skin).
4. Improve diagnosis, education and self-assessment of diabetes.
5. Reduce heart disease mortality rates by tailoring prevention, diagnosis and treatment interventions to specific Vermont communities, reduce heart disease co-morbidities of high blood pressure and smoking.
6. Reduce sexually transmitted diseases such as HIV and chlamydia through improved education and outreach, especially to teenagers.
7. Improve immunization rates against chickenpox, influenza/pneumonia.
8. Address maternal and child health: reduce infant mortality, improve average birth weight, reduce teen pregnancy, improve prenatal care.
9. Prevent suicide/suicide attempts, improve diagnosis of depression.
10. Improve oral health through counseling and preventive dental visits.
11. Improve asthma diagnosis and disease management, decrease COPD deaths.
12. Improve nutrition education, increase physical activity levels of adults and children.

## *APPENDIX D: OVHA PROGRAMS' BENEFITS COVERAGE as of February, 2001*

| | Service | Medicaid/ Dr. Dynasaur | PC Plus Medicaid/ Dr. Dynasaur | VHAP Limited | PC Plus VHAP |
|---|---|---|---|---|---|
| 1 | Ambulance | Y | Y | Y | Y |
| 2 | Certified Nurse Midwife | Y | Y | Y | Y |
| 3 | Chiropractic | Y | Y | N | Y |
| 4 | Community Mental Health Center | Y | Y | Y | Y |
| 5 | Dental (Children) | Y | Y | N | N |
| 6 | Dental (Adults) | Y | Y | N | Y |
| 7 | Diabetic Supplies | Y | R | Y | R |
| 8 | Medical Equipment | Y | R | N | R |
| 9 | Emergency Room | Y | Y | Y | Y |
| 10 | Eye Exams | Y | Y | N | Y |
| 11 | Eyeglasses | Y | Y | N | Y |
| 12 | Family Planning | Y | Y | Y | Y |
| 13 | Gynecological Services | Y | Y | Y | Y |
| 14 | Home-Based Waivers | Y | N | N | N |
| 15 | Home Health Nursing | Y | R | Y | R |
| 16 | Home Health Aid | Y | R | Y | R |
| 17 | Hospice | Y | R | Y | R |
| 18 | Immunizations | Y | Y | Y | Y |
| 19 | Inpatient Hospital | Y | Y | Y | Y |
| 20 | Lab Tests and X-rays | Y | R | Y | R |
| 21 | Maxillofacial Surgery | Y | R | Y | R |
| 22 | Medical Supplies | Y | R | Y | R |
| 23 | Mental Health Counselors | N | Y | N | Y |
| 24 | Nurse Practitioners | Y | Y | Y | Y |
| 25 | Nursing Facility | Y | N | N | N |
| 26 | Nutrition Therapy | Y | R | Y | R |
| 27 | Occupational Therapy | Y | R | Y | R |
| 28 | Ophthalmologist | Y | R | Y | R |
| 29 | Optometrist | Y | Y | Y | Y |
| 30 | Organ Transplants | Y | R | Y | R |
| 34 | Orthotics | Y | R | N | R |
| 32 | Outpatient Hospital | Y | R | Y | R |
| 33 | Over-the-Counter Drugs | Y | R | N | R |
| 34 | Physical Therapy | Y | R | Y | R |
| 35 | Physician Services | Y | Y | Y | Y |
| 36 | Podiatry | Y | R | Y | R |
| 37 | Prescription Drugs | Y | R | Y | R |
| 38 | Prosthetics | Y | R | N | R |
| 39 | Psychiatrist | Y | Y | Y | Y |
| 40 | Psychologist | Y | Y | Y | Y |
| 41 | Psychiatric Hospital | Y | Y | N | Y |
| 42 | Respiratory Therapy | Y | R | N | R |
| 43 | Skilled Nursing Facility | Y | Y | N | Y |
| 44 | Speech Therapy | Y | R | Y | R |
| 45 | Substance Abuse Treatment | Y | Y | Y | Y |
| 46 | Transportation | Y | Y | N | N |

**Key:**
**Y** = covered service (PCP referral not required);
**R** = covered service (PCP referral required);
**N** = non-covered service.

# Appendix C:
# State Programs to Expand Health Insurance Coverage

The Lewin Group

# State Programs to Expand Health Insurance Coverage

**Presented to:**
**The Vermont State Planning Grant Steering Committee**

**by:**
**John Sheils**
**Joan DaVanzo**

**The Lewin Group, Inc.**

**March 26, 2001**

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# Options to Expand Insurance Coverage

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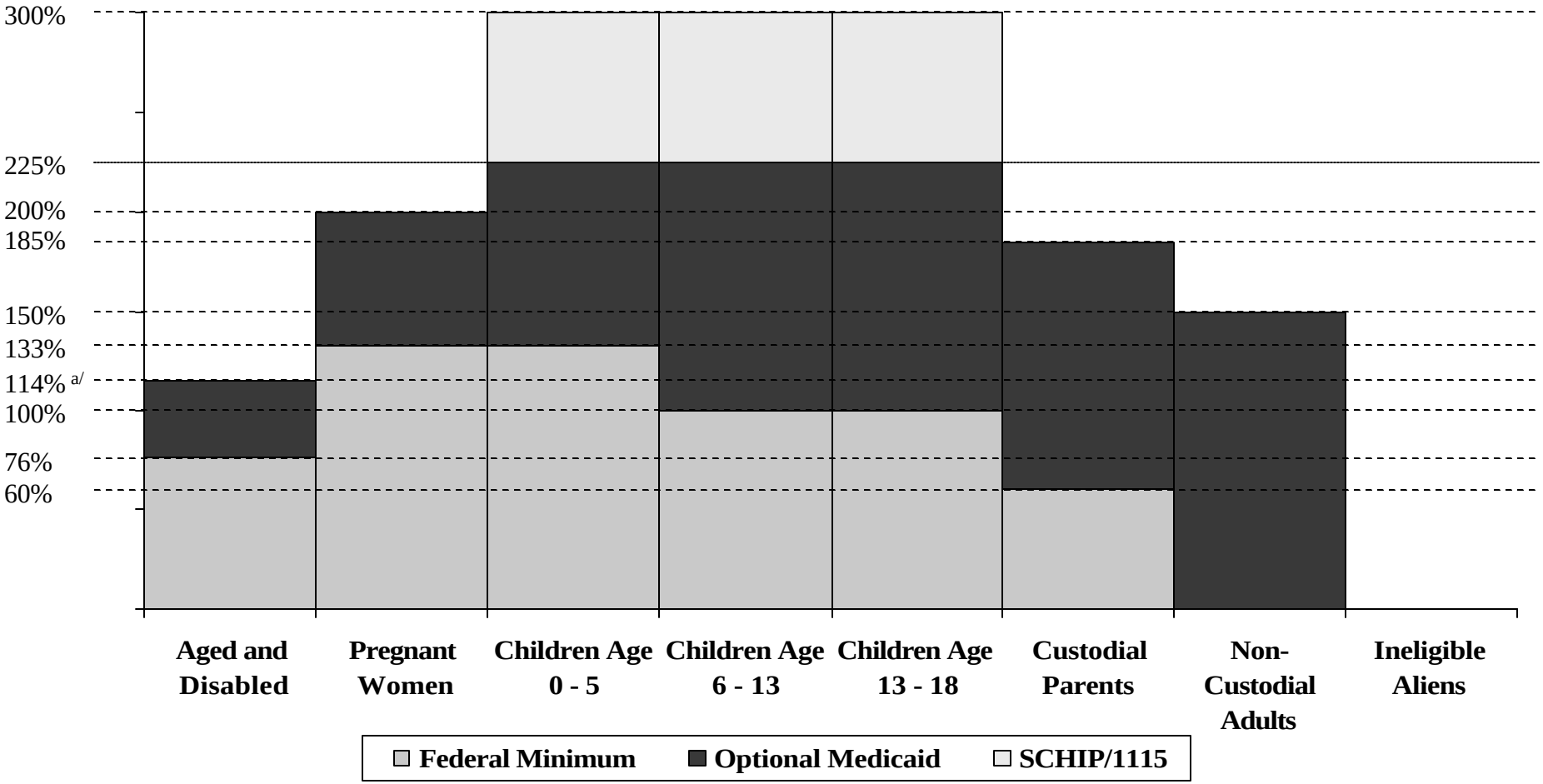
- **Expand Coverage Under Existing Programs**
  - **Medicaid Expansion**
  - **SCHIP Waivers**
  - **Medicaid Coverage for Women With Breast or Cervical Cancer**
- **Expand Private Coverage**
  - **Direct Subsidies to Employees**
  - **Employer Subsidy (e.g., Small Employer Tax Credit)**
  - **Develop Low-cost Benefits Package**
- **Fund Increase in Direct Services to Uninsured**
  - **Expanded Clinics and Hours Available**
  - **State Funds to Help Compensate Free Care Providers**
- **Single Payer**

# Eligibility for the Medicaid and State Children's Health Insurance Program (SCHIP)

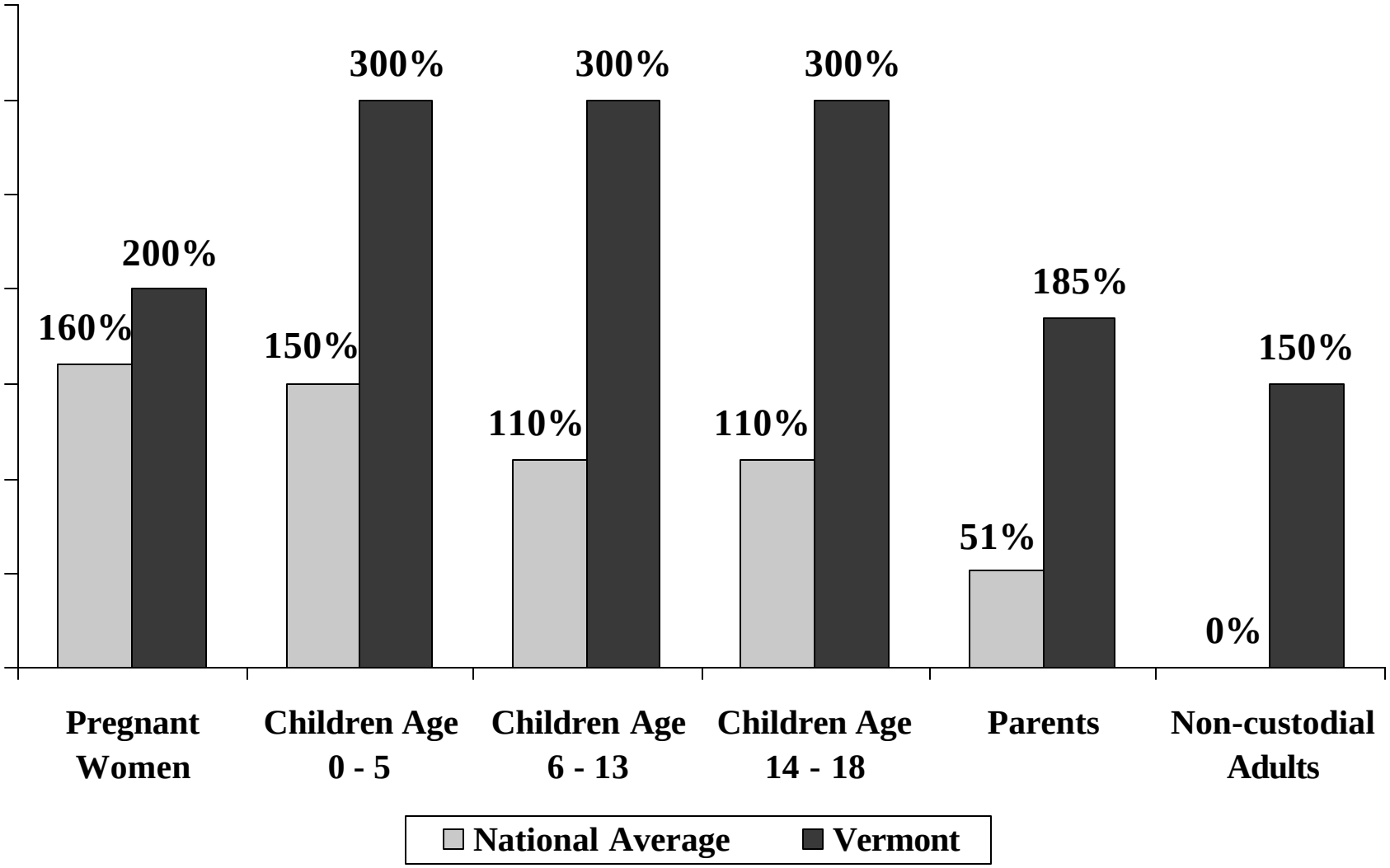
# Summary of Income Eligibility Levels as a Percentage of the Poverty Level for Medicaid and SCHIP in Vermont




a/ The income eligibility level for aged and disabled persons is equal to 114 percent of the FPL in Chittenden County and 105 percent of the FPL in the rest of the state.

# Comparison of Vermont Income Eligibility Levels as a Percentage of the Federal Poverty Level with National Averages

The Lewin Group




a/ Working disabled are eligible through 250 percent of FPL

# Seamless Program Design for Applicants

The Lewin Group

Family #1

-- 1 Parent
-- 3 Children

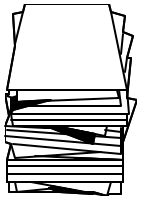
Family #2

-- 2 Parents
-- 3 Children

All Applicants Experience the Program in the Same Way

-- Single Simplified Form

-- Mail-in Application



-- Outreach

-- Continuous Enrollment
(Generally 12 months for Children)

-- Uniform Core Benefits in Family (Extra Benefits for Kids)

-- Applicants shielded from program complexities

SCHIP Program and Funding

Enhanced Match
-- 73% in Vermont

Regular Medicaid Program and Funding

Regular Match
-- 62% in Vermont

State-of-the-Art Enrollment Model

# SCHIP Option to Buy Into Employer Sponsored Coverage

The Lewin Group

- **Cost Effectiveness**
  - **Cost to State Must Be Less Than If on Regular SCHIP**
- **Minimum Employer Premium Participation**
  - **Employer Must Pay "Substantial Portion" of Premium**
  - **HCFA Formerly Set This at 60 Percent of Premium**
- **Minimum Benefits Standard**
  - **State Must Provide Wrap-around Coverage for Medicaid Services Not Provide by Employer**
- **Crowd-out Provision**
  - **Prevent Substitution of Public for Private Coverage**
  - **Must Wait Six Months Since Last Covered Under Employer Plan**
- **Vermont Does Not Buy-in Under SCHIP**
  - **Four States Under SCHIP (Massachusetts, Maryland, . . .)**
  - **Six States Regular Medicaid (Iowa, New Jersey, . . . )**

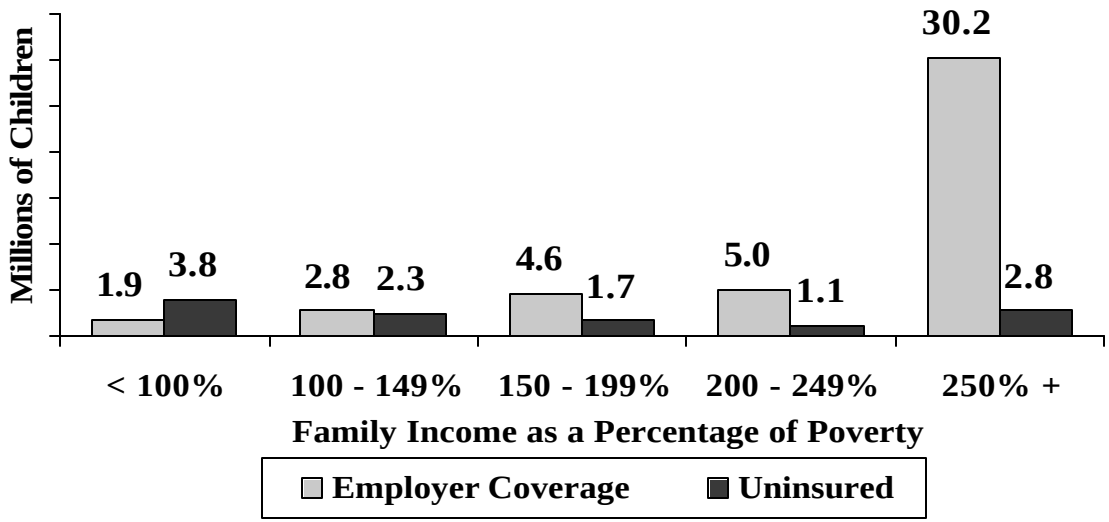
# Expanding Coverage for Families Under Public Programs

# Reasons for Extending Coverage to Families

The Lewin Group

- **Increase Coverage**
- **Studies Show Increased Enrollment of Children If Parent Also Eligible**
- **Encourages Appropriate Use of Health Services**
- **Employer Coverage Often Available for Higher Income**

**Primary Insurance Status of Children Under Age 19 by Family Income, 1997**



# Methods for Expanding Coverage for Parents

The Lewin Group

| Method | Requirement | Federal Funds | States Using Option |
|---|---|---|---|
| **1931(b)** | Plan amendment to exercise state option | Federal match (62% in Vermont) | Vermont, Rhode Island, Wisconsin, and others |
| **Medicaid 1115 Wavier** | Must generate savings for currently eligible to pay for newly eligible | No net increase in federal funds | Delaware, Vermont, Massachusetts and others |
| **SCHIP Waivers Approved** | Pay employer premium for entire family if less than cost of covering children only under SCHIP | No net increase in federal funds | Massachusetts, Wisconsin, and Mississippi |
| **SCHIP Waivers Pending** | Cover parents under SCHIP | Access to unused SCHIP allotments (73% match in Vermont) | Rhode Island, Wisconsin, others (awaiting approval) |
| **State-only Programs** | State has freedom to set benefits and eligibility as they choose | No net new federal funding | Tennessee, Washington, others |

Source: National Conference of State Legislatures, :Expanding Health Coverage to Working Families: State Options," June 2000; Robert Wood Johnson Foundation, "State of the States," January 2001; and Robert Wood Johnson Foundation, "State Approaches to Expanded Family Coverage."

# Example Family Coverage Programs

# States Covering Parents Through SCHIP

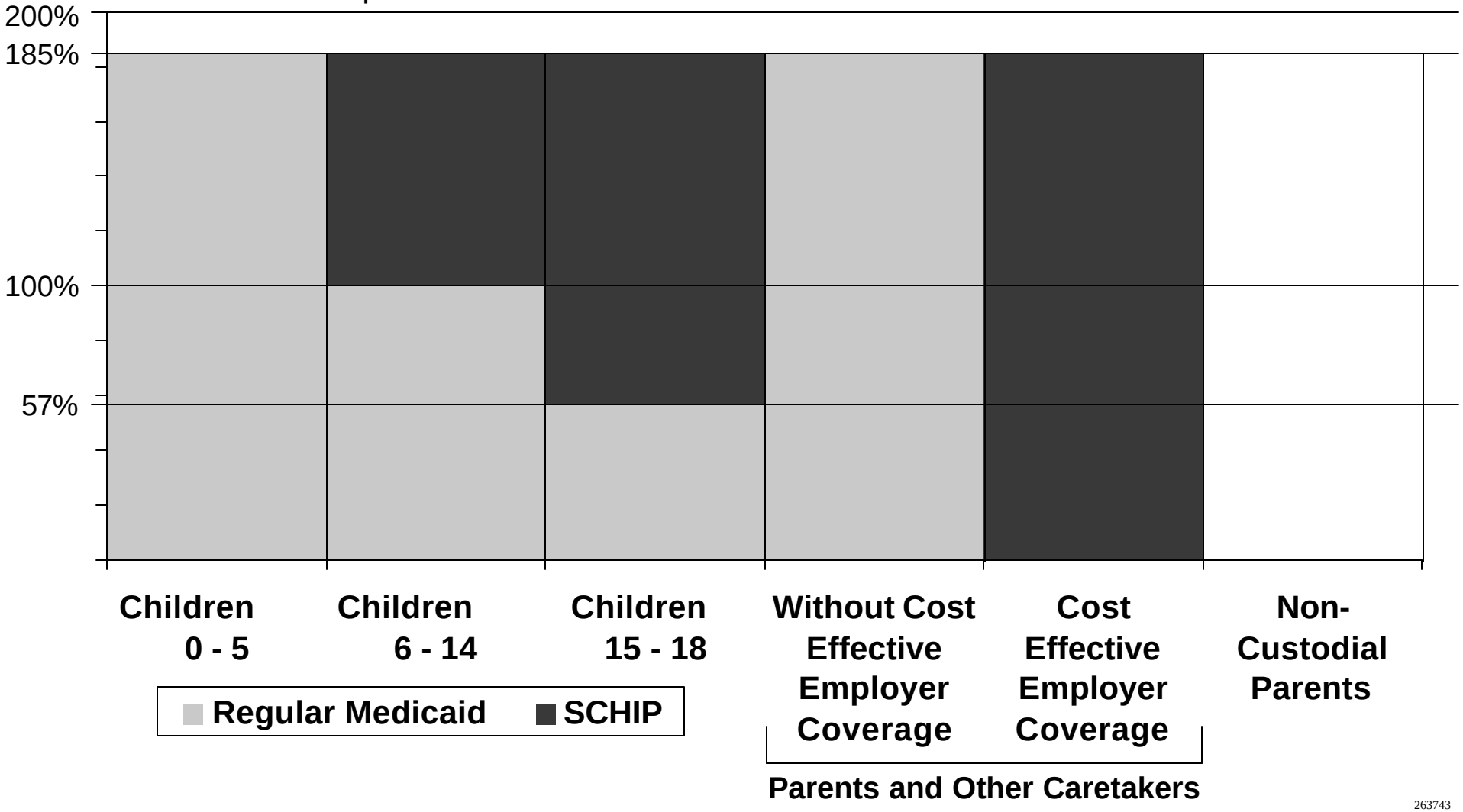
The Lewin Group

| State | Program | Maximum Income (%FPL) | Notes |
|---|---|---|---|
| **Massachusetts** | MassHealth Family Assistance | 200% | Parents above 133% FPL covered through employer only if cost effective. No coverage over 150% FPL for other parents. Parents under 133% FPL are covered under regular Medicaid. 619 parents enrolled. |
| **Mississippi** | MS CHIP | 200% | Family coverage through employer buy-in approved by HCFA but not yet implemented |
| **Wisconsin** | BadgerCare | 185% | Parents are covered through employer if cost effective; Medicaid if not cost effective with regular matching rate. 2,000 parents enrolled. |

Source: Robert Wood Johnson Foundation, "Issue Brief: State Approaches to Expanding Family Coverage," May 2000

# The Wisconsin "BadgerCare" Program

BadgerCare enrollees remain eligible to 200 percent of federal poverty level (FPL) if income rises above 185 percent of FPL



# BadgerCare Employer Buy-in

The Lewin Group

- **SCHIP Pays Employee Premium Share for Parents and Children If Cost Is Less Than If Covered Children <u>Only</u> Under SCHIP**
  - **Typically Occurs Where Employer Pays 60 to 80 Percent of Family Premium**
  - **Pay With SCHIP Enhanced Match (i.e., SCHIIP Waiver)**
- **Medicaid and SCHIP Pay the Family Premium If Less Than the Cost of Covering Both the Parent and Children**
  - **SCHIIP Enhanced Match for Children**
  - **Regular Medicaid Match for Parents**
- **Family Eligible Only If Without Employer Coverage for at Least Six Months**

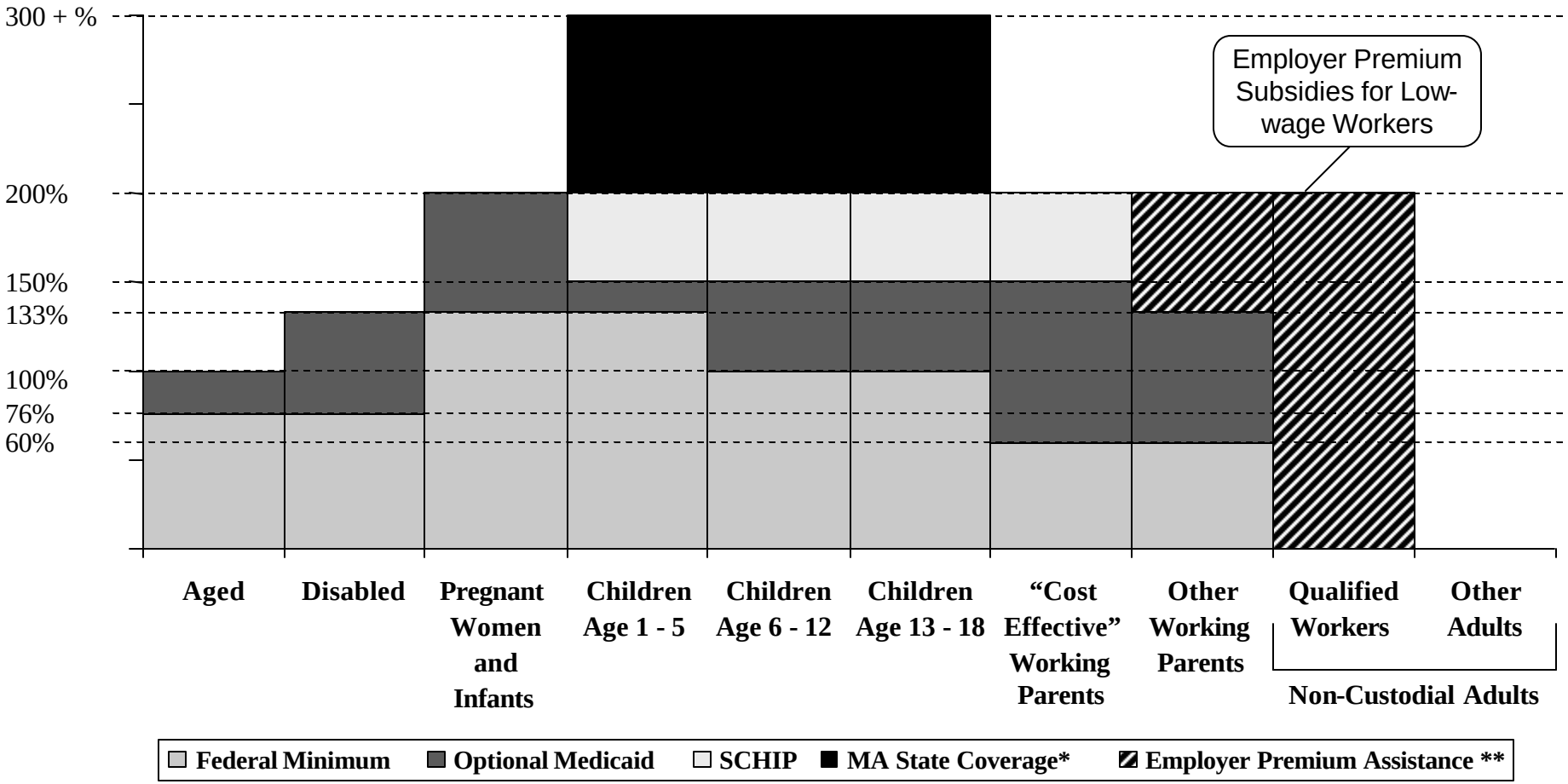
# BadgerCare Performance

The Lewin Group

- **Seamless Program Design for Applicants - One Application for All in Family**
- **High Enrollment**
  - **80 Percent of Uninsured Children**
  - **50 Percent of Eligible Uninsured Adults**
- **Few Enrolled in Employer Buy-in Because of Cost-effectiveness Test**
- **Enrollment May Be Delayed While Waiting for Open Enrollment Period for the Employer Plan**

# Summary of Income Eligibility Levels as a Percentage of the Poverty Level for Medicaid and SCHIP in Massachusetts

The Lewin Group




People with HIV up to 200% FPL covered through MassHealth.

* For children under 18 who are uninsured for primary or preventive health care and not eligible for coverage through MassHealth

** MassHealth Premium Assistance qualifies working adults to 200% FPL of qualified employers for premium subsidy

# States Providing Coverage to Adults through State only Programs

The Lewin Group

| | Eligibility | Subsidy | Enrollment | Financing |
|---|---|---|---|---|
| **Washington Basic Health Plan** | Income below 200% of the FPL, employers and other sponsor groups may buy in at full actuarial cost | Premium contribution ranges from $10 per month to the full actuarial cost by age, income, family size and health plan | 131,250 | Tobacco settlement funds, hospital tax, and alcohol and tobacco tax |
| **MinnesotaCare** | Families with children below 275% of FPL (175% for individuals and couples without children), uninsured past four months, no access to employer coverage paying 50% or more of premium, employer has not dropped coverage in past 18 months | Enrollee pays premium on a sliding scale with income and family size | 116,472 | Enrollee premiums, 1.5% tax on providers, and some Medicaid waiver funds |

Source: Robert Wood Johnson Foundation, "Issue Brief: State Approaches to Expanding Family Coverage," May 2000

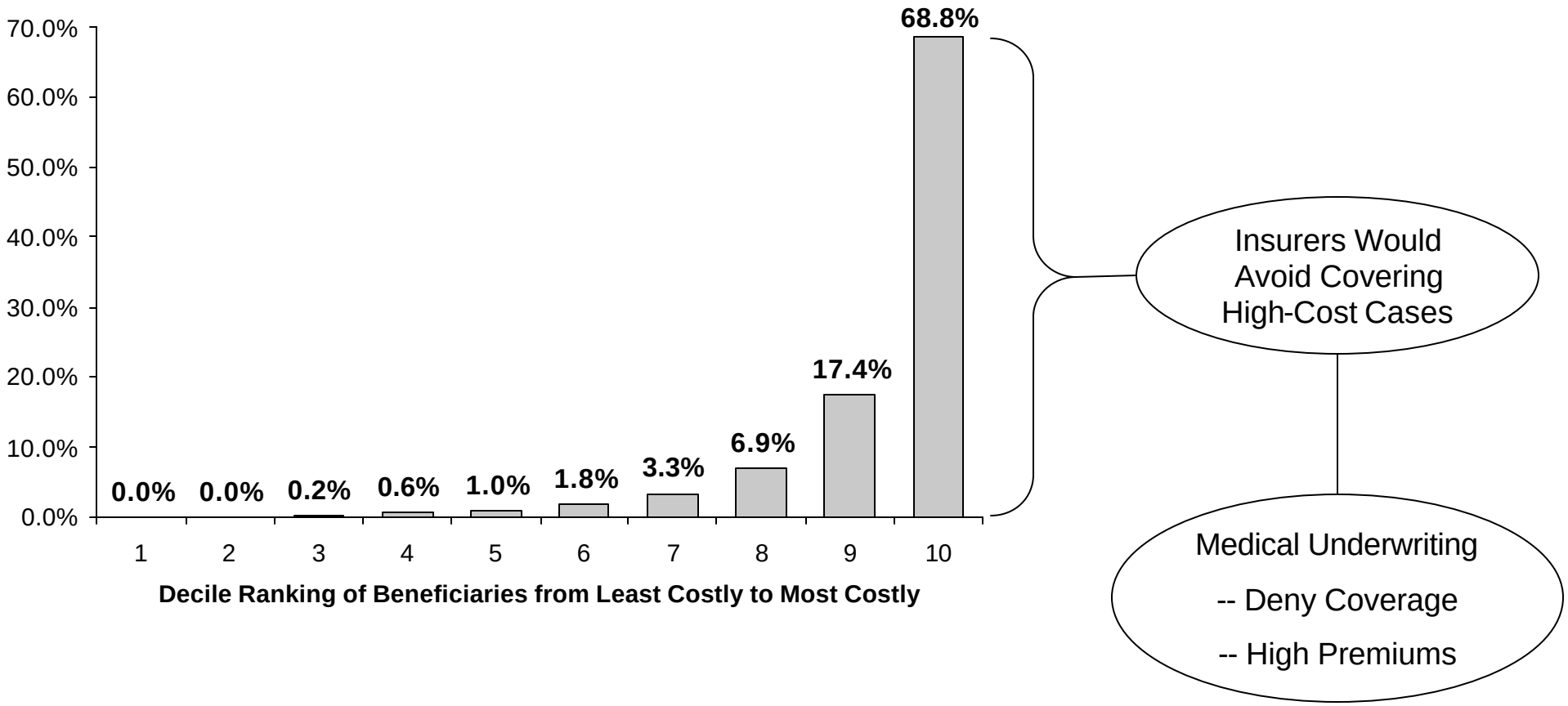
# State-only Programs

The Lewin Group

- **Advantages**
  - **State Is Free to Set Benefits Package**
  - **Can Cap Enrollment at Budgeted Level**
  - **Eliminates Time-consuming Waiver Process**
- **Disadvantages**
  - **No Federal Matching Funds**
  - **There Could Be Maintenance of Effort Requirements in Future Medicaid Expansions**
  - **Difficult to Integrate With Medicaid for Other Family Members**

# Private Health Insurance Market

# Risk Selection in Private Market Created Need for Regulation




Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

# Regulation of Health Insurance

The Lewin Group

- **Health Insurance Portability and Accountability Act (HIPAA), 1996**
  - **Applies to Insured Workers Changing Health Plans**
  - **Guaranteed Issue**
  - **Portability: No Pre-existing Condition Exclusions for Continuously Insured Persons**
  - **Permits Rating by Health Status, Age or Other Risk Factors**
- **Most States Have Additional Regulations Concerning:**
  - **Guaranteed Issue for Non-HIPAA Population in Individual Market**
  - **Rating Bands: Limitations on Premium Variation With Risk Factors**
  - **Community Rating: No Premium Variation With Risk Factors**
  - **More Restrictive Pre-existing Condition Limits**

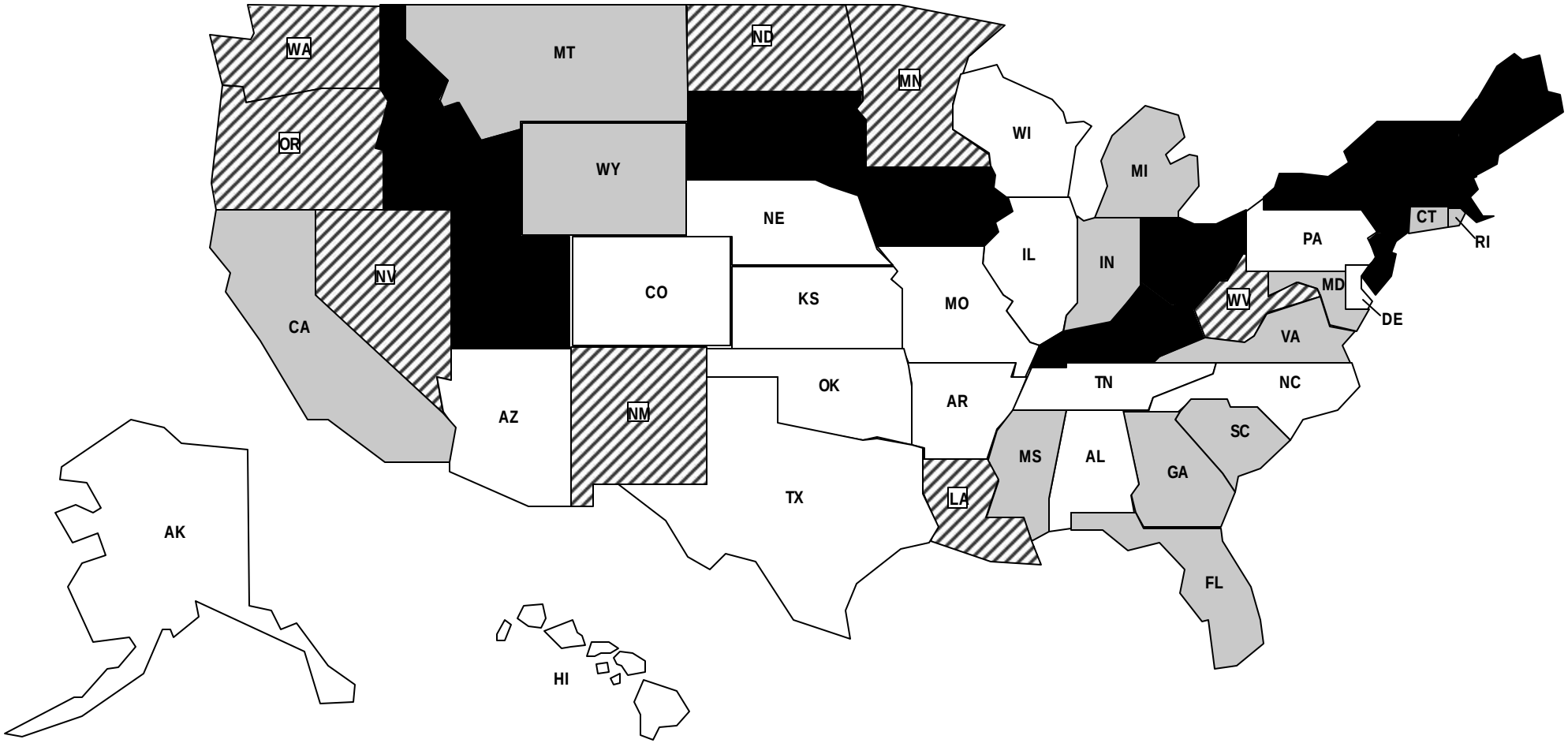
# Vermont's Individual and Small Group Reforms

The Lewin Group

| Reform Element | Explanation |
|---|---|
| **Guaranteed issue** | Insurers must not decline coverage for any product they choose to sell in either individual or small group market. HMOs must sell in the individual market. Insurers can require 75% enrollment of small groups |
| **Standard benefits** | A standard indemnity plan must be offered in the small-group market along with tailored plans, but no standard plan is required in the individual market. |
| **Community rating** | HMOs and Blue Cross must use pure community rating, which means adjustments are allowed only for family size and plan design. Commercial indemnity insurers may also adjust ± 20 percent (phased out in small group market). |
| **High-risk pool/ reinsurance** | A reinsurance mechanism was authorized but not implemented |
| **Association health plans** | Exempt from community rating but must guarantee issue and "community rate" participants within association<br>- - 60 percent of market<br>- - Premiums up to 33 percent lower than small group rates |
| **Loss ratio limit** | Seventy percent |

# State Map Individual Market Insurance Reform Laws

The Lewin Group




Guaranteed Issue and Rating Rules

Rating Rules Without Guaranteed Issue

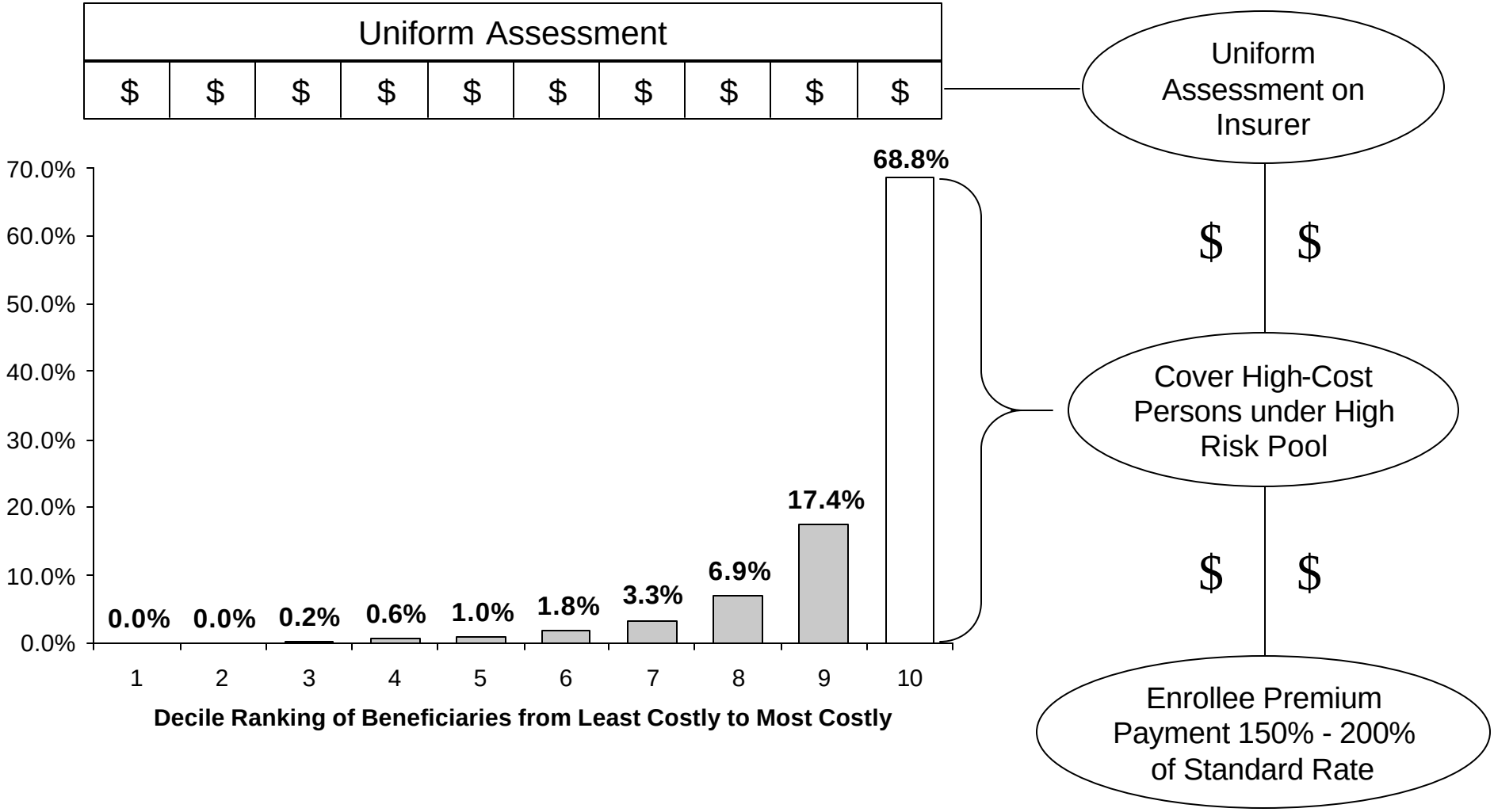
Pre-existing Condition Limits Only

Guaranteed Renewal Only

Source: Blue Cross and Blue Shield Association, December 2000

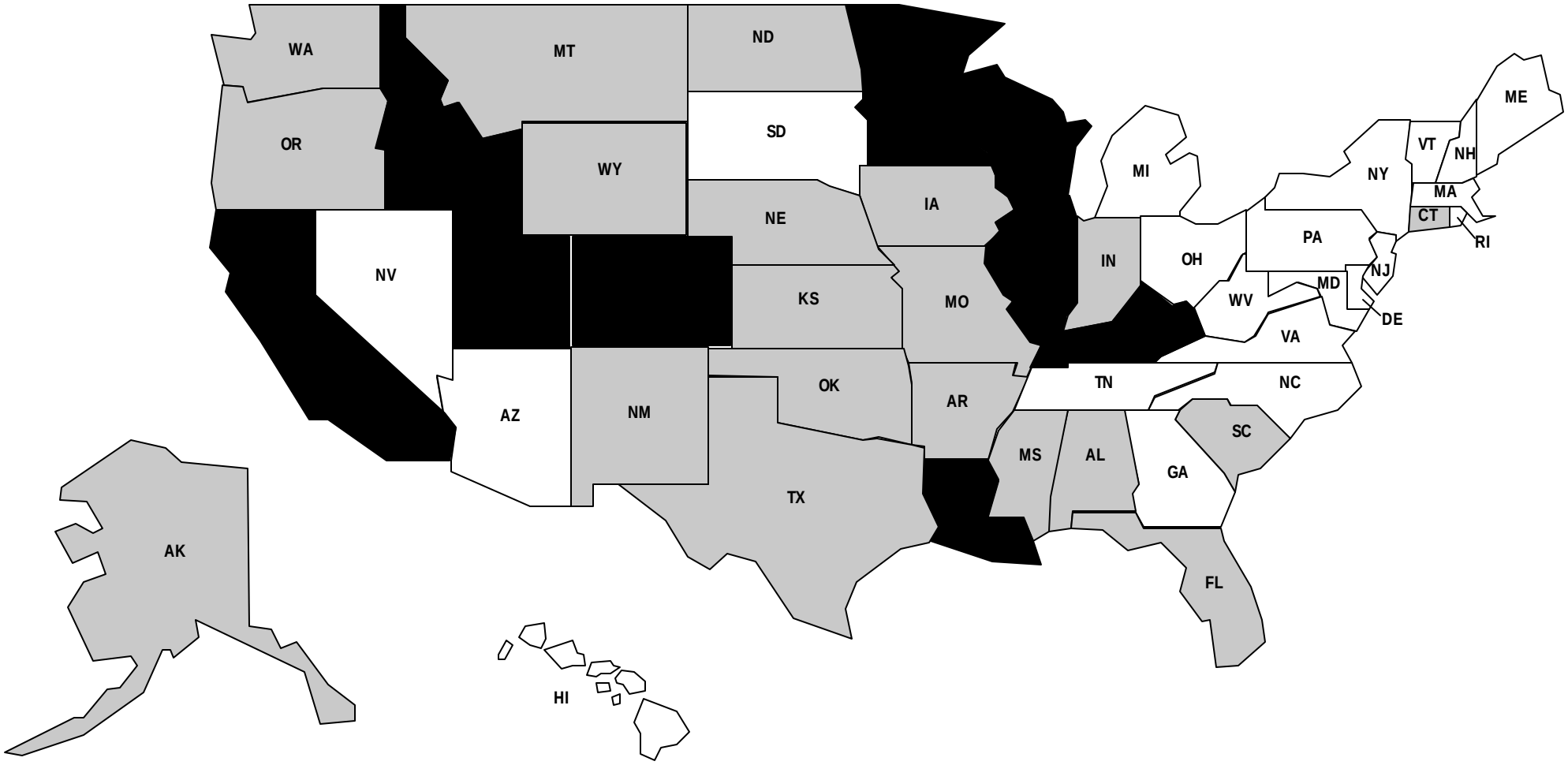
# Operation of a Typical High Risk Pool: Does Not Exist in Vermont

The Lewin Group



# State High-Risk Health Insurance Pools Map

The Lewin Group




Non-Assessment Revenues

Assessment on Insurance

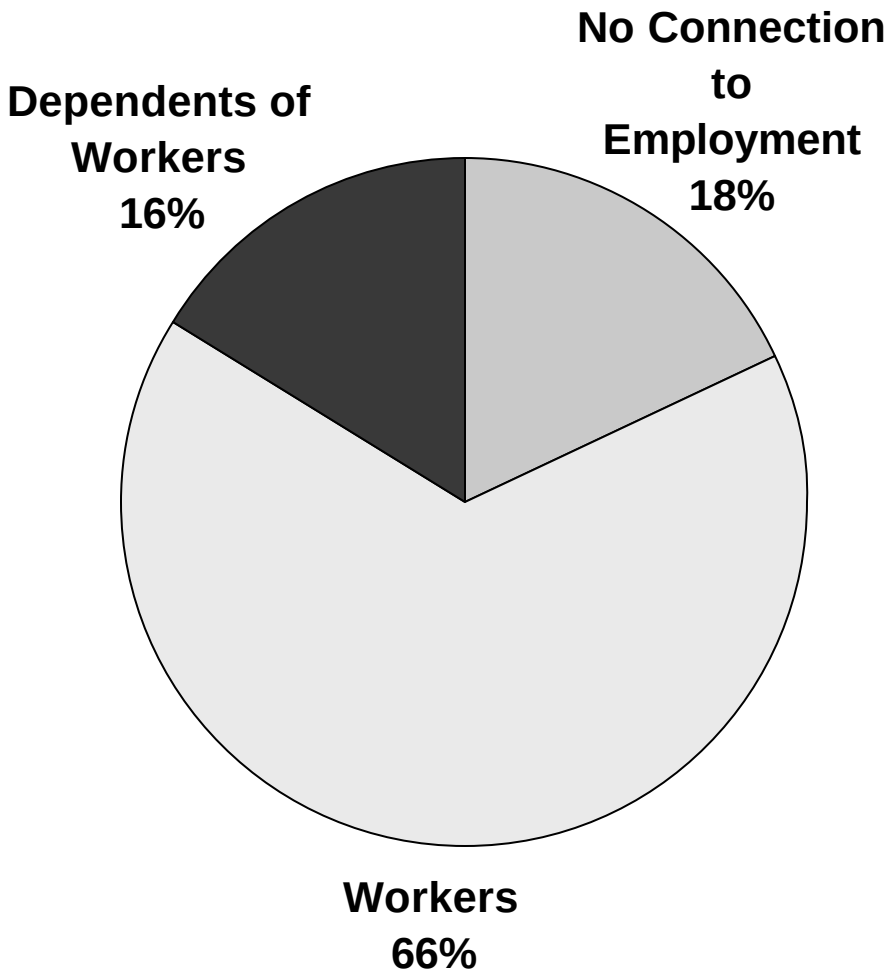
No High Risk Pool

Source: Communicating for Agriculture, 2000, and Blue Cross and Blue Shield Association, December 2000

# Expanding Private Coverage

# Distribution of the Uninsured in Vermont by Work Status in 1997

The Lewin Group




Total Uninsured in 1997 = 40,067

Source: Estimated from the 1997 Vermont Household Survey Data.

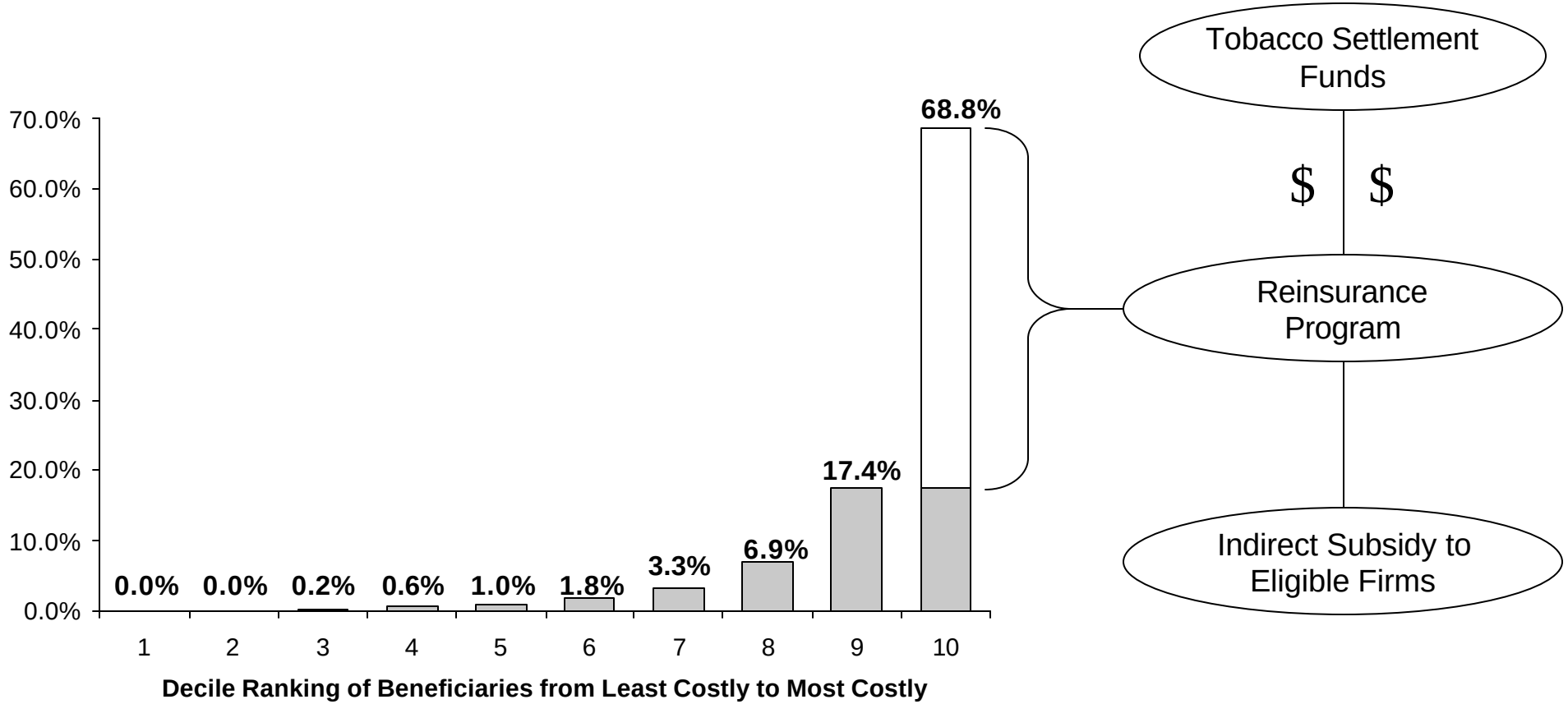
# “Healthy New York” Program - Subsidized Coverage for Small Businesses in New York

The Lewin Group

- **Eligibility Limited to Firms:**
  - **50 or Fewer Workers With at Least Half Enrolling in Plan**
  - **Have Not Offered Coverage in Prior Year**
  - **Less Than 30 Percent of Workers Earning Over $30,000**
  - **Employer Pays at Least Half of Premium**
- **Insurers May Offer Lower Cost Benefits Package**
  - **Exempt From Benefit Mandates - Chiropractic, Alcohol and Drug, Home Health**
  - **No Mental Health**
  - **$500 Deductible, $100,000 Maximum Per Beneficiary**
- **Reinsurance**
  - **90 Percent of Costs Between $30,000 and $100,000**
  - **Subsidized With Tobacco Settlement Funds**
- **Similar Program for Individual Market**
  - **Self-employed and Individuals Below 250% of FPL**
  - **Uninsured for Prior 12 Months**

# Healthy New York Subsidized Insurance for Small Groups Through State-funded Reinsurance

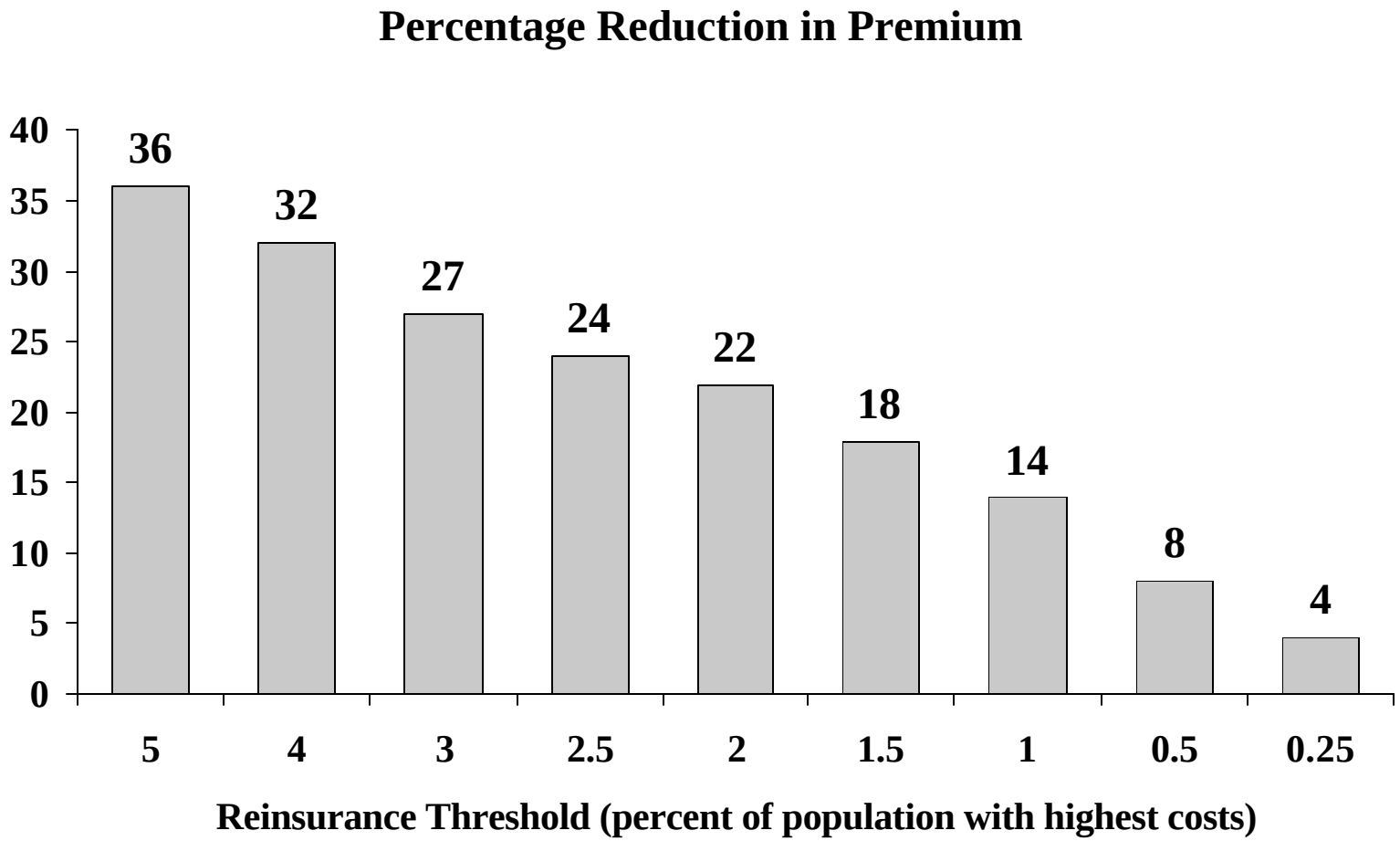
The Lewin Group




Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

# Effect of Reinsurance on Premiums

The Lewin Group




Source: Based on tabulations by Actuarial Research Corporation, September 2000.

# Massachusetts Employer Coverage Subsidies

The Lewin Group

## Insurance Partnership - Employer Subsidy

- **Eligible Firms**
  - **50 or Fewer Workers**
  - **Contribute at Least 50% of Premium**
  - **Offers Comprehensive Coverage**
- **Subsidy of $400 for Each Worker ($800 for Family) Below 200% FPL**

## Premium Assistance Program - Individuals

- **Eligible Individuals**
  - **Self-employed**
  - **Full-time Worker in Firm With 50 or Fewer Workers**
  - **Workers With Children**
  - **Incomes Below 200% of FPL**
  - **Employer Offers Comprehensive Coverage**
- **Pays Employee Contribution up to:**
  - **Full Amount for Those Below 100% FPL**
  - **Full Amount Less $30 Per Family ($50 Per Couple) for Those Between 100% and 200% of FPL**

# States Providing Private Premium Subsidies

The Lewin Group

| | Eligibility | Subsidy | Enrollment | Financing |
|---|---|---|---|---|
| **Arizona Premium Sharing Program** | Gross income below 200% of FPL (400% for chronically ill), uninsured at least six months | Premium capped at 4% of income for families and 2.5% of income for singles | 6,276 | Tobacco Tax |
| **Oregon Health Insurance Assistance Program (FHIAP)** | Gross family income under 170% of FPL, uninsured at least six months, assets less than $10,000 | Subsidy varies with income<br><125% FPL: 95%<br>125% - 150% FPL: 90%<br>150% - 170% FPL: 70% | 4,131<br>waiting list of 23,369 | Tobacco Tax |
| **Massachusetts Premium Assistance Program** | Workers with children, full-time workers in small firms (50 or fewer workers), income below 200% of FPL, and employer coverage is comprehensive | Subsidy varies with income<br>< 100% of FPL: Full subsidy<br>100% - 200% FPL up to $30 per month per family ($50 per couple) | 10,000 | State-only funding; Medicaid/SCHIP where possible |

Source: Robert Wood Johnson Foundation, "Issue Brief: State Approaches to Expanding Family Coverage," May 2000

# Limited Success of Strategies for Making Health Insurance More Affordable

The Lewin Group

| Project | Insurance plan innovation | | | Subsidy option | | | | Target market penetration |
|---|---|---|---|---|---|---|---|---|
| | Limited benefits option | Major cost sharing | Very limited provider network | Direct premium subsidies | Indirect subsidies | Provider discounts | Link to state high-risk pool | |
| Central Alabama Coalition (BasicCare) | ✓ | | ✓ | | | ✓ | | 0.1% |
| Arizona (Health Care Group) | ✓ | | | | ✓ | ✓ | | 5.0% |
| Colorado (SCOPE) | | ✓ | | | | ✓ | | 3.7% |
| Florida Health Access Corporation | | | | ✓ | ✓ | ✓ | | 5.0% |
| MaineCare | | | | ✓ | ✓ | ✓ | ✓ | 14.0% |
| Michigan (One-Third Share Plan) | | | | ✓ | | ✓ | | 6.7% |
| Tennessee (MedTrust) | ✓ | | | | | ✓ | | 1.3% |
| Utah (Community Health Plan) | | ✓ | ✓ | | ✓ | ✓ | | 3/5% |

Source: Helms, D., et al., "Mending the Flaws in the Small Group Market," *Health Affairs*, Summer 1992.

# Small Employer Purchasing Pools

# Goals of Employer Purchasing Pools

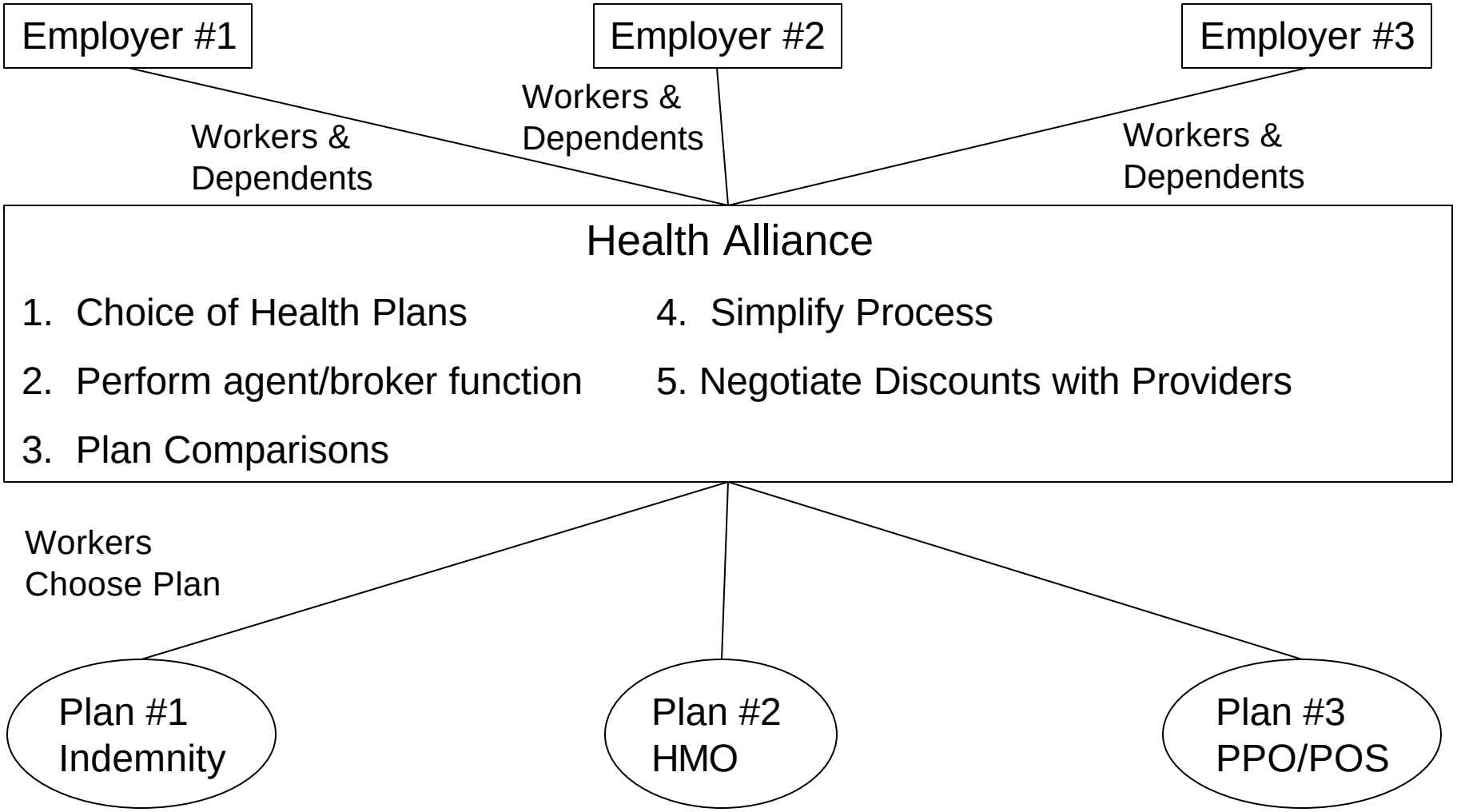
The Lewin Group

- **Aggregate Purchasing Power in Small Group Market**
- **Increase Competition in Small Group Market**
- **Lower Premiums**
- **Reduced Administration**
- **Increased Coverage**
- **Greater Choice for Workers**
- **Multiple Plans Rather Than Single Plan Offered by Associations**

Source: Kahn C., Pollak, R.., "Have Small Group Health Insurance Purchasing Alliances Increased Coverage?," *Health Affairs*, 20(01)m 154-163, 2000.

# Health Alliance Is Designed to Provide Access to a Choice of Health Plans Competing on the Basis of Price and Quality

The Lewin Group



# Performance of Alliance: California, Connecticut and Florida

The Lewin Group

- **Premium Reduction in California Only**

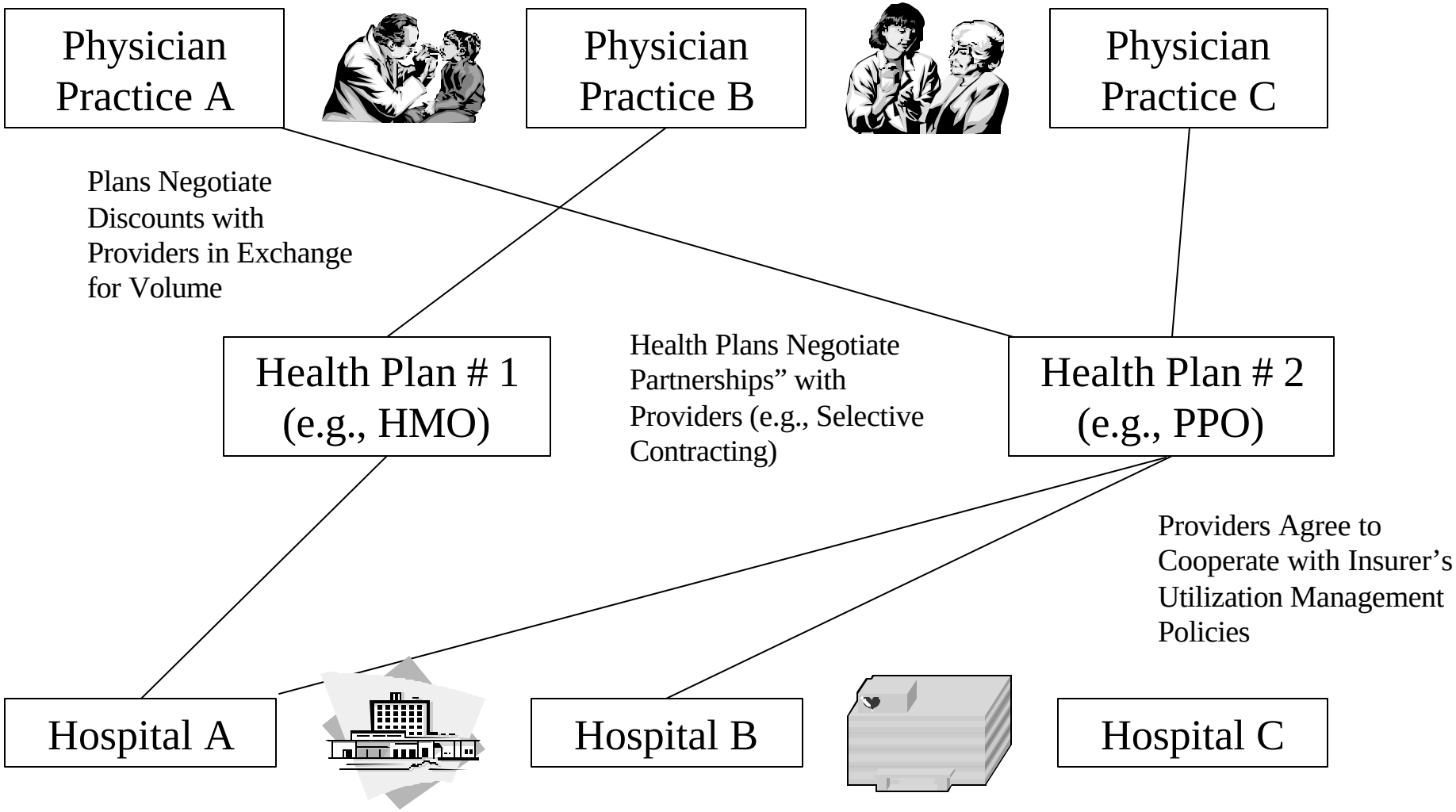
**Employee-only Coverage Monthly Premium, 1997**

| | California | | Connecticut | | Florida | |
|---|---|---|---|---|---|---|
| | In Alliance | Out of Alliance | In Alliance | Out of Alliance | In Alliance | Out of Alliance |
| HMO | $130 | $154 | $188 | $189 | $155 | $151 |
| PPO/POS | $166 | $193 | $217 | $232 | $192 | $186 |

  - **High Provider Competition in California**
  - **Florida, Connecticut Alliances Could Not Negotiate with Providers**
- **More Rapid Shift to Managed Care - Savings**
- **No Administrative Savings**
- **No Increase in Employers Offering Coverage**
- **Low Enrollment**
  - **Underestimated Importance of Broker**
  - **Florida Alliance Closed**

# Achieving Savings by Aggregating Purchasing Power Requires Competition Among Providers

The Lewin Group



# State Tax Subsidies for Insurance

# State Tax Incentives for Coverage

The Lewin Group

| **Tax Benefits for Individuals** | |
|---|---|
| Full deduction for self-employed | California, Delaware, Georgia, Idaho, Illinois, New Jersey, Wisconsin |
| Deduction for non-group insurance | Colorado, Iowa, New Mexico, (phase out with income) Utah |
| Refundable tax credit for group insurance | North Carolina: $300 phased out with income |
| **Tax Benefits for Employers** | |
| Refundable tax credit for firms that offer coverage | Kansas: $35 per employee per month or 50% of total premium, phased out by the sixth year offering coverage |
| Non-refundable tax credit for small employers (under 5 workers) with lower wage workers | Maine: lesser of $135 per employee with dependent or 20 percent of |

# Appendix D:
# Views on Health Insurance and the Uninsured in Vermont: A Qualitative Study

# Views on Health Insurance and the Uninsured in Vermont: A Qualitative Study

*June 18, 2001*

**Action Research and**
**The Lewin Group, Inc.**

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## EXECUTIVE SUMMARY

The Office of Vermont Health Access (OVHA) commissioned Action Research to conduct a series of focus group sessions and in-depth interviews to gauge employer reasoning toward offering health insurance to employees as well as obtain a better understanding of the views of Vermont residents who do not have health insurance. Focus group discussions involving up to 10 individuals were set up and led by a trained moderator. Focus groups are useful in exploring attitudes and preferences that can not be revealed through survey research. This qualitative research component was designed to facilitate analyses of options to expand coverage in Vermont under the State Planning Grant funded by the Health Resources and Services Administration (HRSA).

Separate focus group sessions were conducted with employers and uninsured persons. There were 16 focus groups and 11 in-depth interviews with employers, resulting in a total of 135 participants. The purpose of the focus groups and interviews with employers was to: (1) identify factors that influence employers' decisions on whether or not to offer health insurance to their employees; and (2) obtain employers' ideas regarding possible ways to expand health insurance coverage in the State of Vermont. There were 16 participants in the two focus groups of uninsured Vermonters. The goals of these focus groups were to: (1) understand the various reasons that the uninsured are without health insurance, and (2) obtain their views on opportunities to expand health insurance in the state.

The use of focus groups and in-depth interviews allowed Action Research to probe deeply into beliefs, motivations, and attitudes about health insurance, generally, and the various options available to both employers and uninsured individuals. The report is organized into five sections. The Executive Summary provides an overview of the main findings from both the employers and uninsured focus groups. The first section clearly lists the objectives of the focus groups and outlines the methodology. The second and third sections discuss the employers' and uninsured peoples' views, respectively, quoting focus group participants directly. Finally, the Conclusion summarizes the focus groups and interviews, highlighting implications for the State Planning Grant study.

### Findings from Employer Focus Groups

Throughout the various employer focus group sessions, it became clear that employers who currently offer health insurance and those who do not offer it share very similar views on health insurance and how to expand coverage. Those who offer it reported being very happy to be able to do so, and proud of their health insurance plans. Most of those not offering it reported they would like to be able to offer insurance. All focus group participants, including those not currently offering health insurance, agreed that employers have a social and moral responsibility to offer it. They seemed to believe it is the *"right thing to do."*

However, nearly all employers in the groups expressed significant frustration with the state of health insurance today and reported having concerns about the future of health insurance. Participants stated that health insurance costs are completely *"out of their control,"* and believe it is impossible to predict, plan or budget for annual health care expenditures.

Few employers currently offering health insurance foresee a time when they will not offer it at all. However, many reported being able to foresee a time when they will need to significantly change the structure of the benefits they offer, either by increasing the employee premium contribution, raising the co-payments or deductibles, or reducing the benefits covered. Small companies were more likely than large ones to report that there might be a time in the future when they could no longer be able to afford to offer health insurance.

Employers who do not offer health insurance identified cost as the primary reason they do not provide coverage. There were several aspects of cost cited by these employers including: premium levels, the unpredictability of costs in the future; and the time required to research and administer plans.

### *Perceived Value of Health Insurance*

? Employers view health insurance as one of the most valuable benefits they can offer, along with paid time off and a retirement savings plan.

? Employers were mixed on whether employees value health insurance as a benefit. For example, some employers, particularly those whose workforces consist primarily of young or low-wage employees, agreed that many of their employees would prefer to have paid time off and higher wages rather than health insurance.

? Participants not currently offering insurance expressed a reluctance to commit to offering health insurance due to rapidly escalating prices.

? Several employers indicated that some employees do not value health insurance coverage because they do not fully comprehend what it costs.

### *Benefits of Offering Insurance*

? Employers who offer health insurance said they do so to attract and retain employees. Employers who do not offer health insurance recognize that this has a negative impact on their ability to recruit employees.

? Other reasons cited for offering insurance include: increasing employee compensation with a tax-free benefit; keeping employees healthy and productive; and having access to group health insurance for themselves.

### *Costs Associated with Offering Insurance*

? All employers expressed anxiety over high premiums and significant fluctuation in the cost of health insurance.

? Some participants stated they could only afford policies with a large amount of cost sharing (i.e., premium contributions, deductibles etc.) making employee out-of-pocket costs so high that many employees are not willing to participate.

? Many employers stated that costs have increased due to state-mandated benefits (e.g., maternity, mental health and chiropractic) and the effects of community rating. Many believe these mandates have caused insurers to leave the state's insurance market, resulting in a lack of adequate competition and higher prices.

? Some employers believe that Vermont does not attract many insurance carriers due to its small size. Others noted that local businesses have a difficult time making enough profit to afford health insurance.

? Many insuring employers pass on some or all of the cost of premium increases to employees in the form of increased employee premium contributions, reductions in covered services or higher deductibles and coinsurance amounts.

### *Current Offerings*

? While health plans vary across employers, most employers offer one plan and split the cost of the premiums with their employees. The employees typically pay about 20 percent of the premium.

? Employers said that administering benefits for part-time or temporary employees would be difficult due to the variability of their work schedules and thus the uncertainty that they will be able to earn enough in wages to pay the employee portion of the premium.

? Some employers believe that health insurance is a reward for making a full-time commitment to a company and, therefore, do not want to offer the benefit to part-time employees.

### *Market Competition*

? Employers believe that increasing the number of insurers competing for business in Vermont would reduce insurance costs.

? Many employers indicated that increased insurer competition would be the most important catalyst to reducing premiums despite increasing health care utilization and costs.

? Employers agreed that there is sufficient access to information on health plans, but feel that it is confusing and is not presented in a way that permits comparisons across plans.

### *Who Should Be Responsible?*

? Most employers believe that it should be the responsibility of employers and the government to ensure that all Vermonters have health insurance. Additionally, most believe it should be:

- ? Government's role to create a hospitable environment for insurers to do business;
- ? Employers' role to offer health insurance to employees; and
- ? Employees' role to maintain their health and refrain from abusing the system.

? Other government responsibilities include providing insurance to those who are not able to work and assisting employers who can not afford to offer insurance to their employees.

? While employers generally had negative feelings about a *"government-funded insurance program"*, they noted that Dr. Dynasaur is an example of a government program that works well.

### *Employer Focus Group Participant Recommendations for Expanding Coverage*

? Participants' expressed that reducing costs is key to expanding insurance coverage and had several suggestions on how to do so:

- ? Devise employer tax incentives to encourage more employers to offer insurance;
- ? Encourage more competition in the health insurance market;
- ? Develop an affordable, basic (not catastrophic) health insurance plan that is free of state mandated benefits;
- ? Permit insurers to charge less for groups who utilize less care;
- ? Form a pool of all persons in the state to negotiate favorable rates with providers and insurers.

- ? Additionally, participants suggested that the state should:

- ? Offer catastrophic health insurance to Vermonters who are without insurance, including part-time and temporary employees;
- ? Provide understandable plan information to facilitate comparison of coverage alternatives;
- ? Provide rebates to employees who maintain good health and employers whose groups have good health overall;
- ? Target individual tax incentives such as Medical Savings Accounts and tax deduction for out-of-pocket medical expenses, regardless of the amount.

- ? A small number of employers recommend that the state require health insurance, either by requiring employers to offer it or by requiring individuals to carry it.

## Findings from Focus Groups with Uninsured Vermonters

Participants agreed that having health insurance is very important for themselves and for their families. Many participants mentioned that not having health insurance makes them uneasy; they worry about what might happen if they became ill or injured. For example, some participants mentioned that they participate in physically demanding jobs, such as landscaping or

construction. These participants noted that if they were injured during these activities they would be forced to pay the full charges of their health care.

Reasons for not having health insurance varied. The majority of participants lost their health insurance coverage because either they or their spouse changed jobs and were no longer offered health insurance benefits through an employer. Some participants work part-time or seasonal jobs which do not offer health insurance. Some chose to leave their jobs to take care of family members at home; others are self-employed. None of the participants thought they could afford private health insurance. The main barrier the uninsured face is the cost of health insurance plans. The majority of participants are not offered health insurance through their employers and believe they can not afford to buy it privately. Participants prioritized paying other household bills before purchasing health insurance.

A wide variety of recommendations for extending health insurance coverage came out of the focus groups of the uninsured. Many of the recommendations include shared responsibility between the state, employers and insurance companies. Many participants recommended expanding eligibility of existing state-funded health insurance programs. Participants also recommended the state consider each case individually, possibly considering mortgage and car payments when determining income caps.

### *Perceived Value of Health Insurance*

? Most uninsured participants agreed that health insurance is very important and that they would like to have it if it was affordable. Most had health insurance at one point in their lives but lost it when they changed employers. Many reported they would enroll in a plan if they received a significant raise or went to work for an employer who offered health insurance.

? Most uninsured participants acknowledged they are gambling with their health. They generally lack preventative care, delay seeking medical care when needed, and seldom have continuous care with one provider.

### *Cost of Health Insurance*

? The main barrier to coverage cited by participants, was cost. A majority of participants are not currently offered health insurance by their employers (or are self-employed) and feel they cannot afford to purchase individual insurance.

? Most of the uninsured indicated that premiums above $100 or $150 per month would be too expensive. They believe that a basic plan, with a $1,000 to $2,500 deductible, should cost about $300 per month. Provisions such as co-pays and deductibles have a significant role in how much participants are willing to pay for insurance.

? Participants believe it is less expensive for them to pay out-of-pocket for health services as used rather than pay a monthly premium. They would work out a payment plan with the provider in the case of a large medical expenditure.

### *Source of Medical Care*

? When medical care is necessary, participants generally prefer to go to a clinic in their area that offers care free of charge or on a sliding-scale fee schedule. A few said they prefer to seek treatment with private health care providers they know, turning to a clinic only if necessary.

? Participants indicated that without clinics which serve uninsured patients, many of the uninsured would not have access to health care or would utilize emergency rooms more often.

### *Who Should Be Responsible?*

? Most participants believe that a combination of the government and employers should be responsible for providing health insurance to Vermonters.

? Many participants are wary of a government-only system such as the Canadian single-payer health care system.

### *Benefits Recommendations*

? Participants indicated that a basic health plan should cover annual physicals, sick doctor visits, prescription drug coverage, emergency care and hospital stays.

? A few participants stated that annual dental visits and routine dental work also should be covered.

### *Uninsured Focus Group Participant Recommendations for Expanding Coverage*

? The following are participant recommendations for expanding insurance coverage:

- ? Extend state outreach activities to educate more people about the plans that already exist;
- ? Expand eligibility for existing state-funded health insurance plans;
- ? Allow patients who do not utilize the health care system often to share cost savings with insurers;
- ? Improve the ability to purchase customized health plans;
- ? Make it possible for part-time and seasonal employees to access health insurance through their employers;
- ? Regulate insurance companies and their profit levels to reduce the cost of health insurance; and
- ? One participant stated that the state should make it mandatory for individuals to have health insurance coverage.

# I. BACKGROUND

## A. Overview

The Office of Vermont Health Access commissioned The Lewin Group and Action Research in order to better understand: (1) employer attitudes toward offering health insurance to employees, and (2) the views of Vermonters without health insurance. The research presented in this report is part of a larger project undertaken by the State of Vermont under the Federal HRSA State Planning Grant. This phase of the research focuses specifically on qualitative research (focus groups and in-depth interviews) conducted with employers. It also includes qualitative findings from focus groups conducted with residents of Vermont who do not currently have health insurance. Action Research conducted a series of sixteen focus groups and eleven in-depth interviews with employers (135 participants) and two focus groups with uninsured persons (16 participants).

The qualitative research had several goals: (1) identify the factors that influence employers' decisions about whether to offer health insurance, and (2) obtain employers' ideas regarding possible ways to expand health insurance coverage in Vermont. The goals of the focus groups with uninsured Vermonters were: (1) understand the various reasons that they are without health insurance, and (2) obtain their views on opportunities to expand health insurance in the state.

The use of focus groups and in-depth interviews allowed Action Research to probe deeply into beliefs, motivations, and attitudes about health insurance in general and the various options available to these individuals.

## B. Objectives

The research with employers specifically addressed the following topics:

? Employers' attitudes toward health insurance today, including how health insurance fits into their views of employee benefits;

? Motivations behind the decision to offer or not to offer health insurance;

? Barriers that employers face in offering health insurance to employees;

? Responsibility for ensuring Vermonters have health insurance coverage;

? Recommendations to increase health insurance coverage in Vermont;

The research with uninsured persons specifically addressed the following four topics:

? Individuals' attitudes toward health insurance, including their views on the consequences of not having insurance;

? The availability of health insurance, and their preferred source(s) of medical care;

? Benefits they would like to have in a health insurance plan, and the amount they would be willing to pay for such a plan;

? Perceptions of Medicaid, and other government-sponsored insurance programs, such as Dr. Dynasaur and Primary Care Plus, and a discussion of the government's role in providing health insurance.

## C. Methodology

To meet project objectives, Action Research conducted a comprehensive qualitative program that included a series of sixteen focus groups with businesses in five areas throughout Vermont. After discussion and consultation with The Lewin Group and Steering Committee members, it was determined that the employer focus groups were to be arranged as follows:

| | Not Offering Insurance | Offering Insurance | | |
|---|---|---|---|---|
| | | Small (1-9 employees) | Medium (10-50 employees) | Large (51+ employees) |
| **Burlington** | 1 | 1 | 1 | 1 |
| **Rutland** | 1 | 1 | | 1 |
| **Newport** | 1 | 1 | 1 | |
| **Bennington** | 1 | 1 | 1 | |
| **Brattleboro** | 1 | 1 | | 1 |

High-level employees responsible for the administration of employee benefits (frequently the owner, president, vice-president or human resources director) were recruited to participate in the discussion. All employer focus group participants were offered a $100 stipend to attend.

Two focus groups were conducted with uninsured Vermonters. These focus groups were conducted in Burlington and Middlebury. The Vermont Coalition of Clinics for the Uninsured was enlisted to recruit participants. Participants were offered a $30 stipend to attend the discussion.

Each of the focus groups was comprised of up to ten individuals. Groups this size create a comfortable and interactive environment in which abstract concepts, rationales, and emotional dimensions of attitudes can be explored in-depth. A number of projective and enabling techniques were employed to engage individuals at an emotional level in order to help uncover deep-seated attitudes and motivations. These techniques included group brainstorming, verbal association, creative drawing, and group decision-making.

The in-depth interviews lasted approximately 45 minutes. The interview guide closely followed the focus group discussion guide. All interviews were conducted by Action Research staff who have professional training in executive interviewing. Projective and probing techniques were also used in the interviews to obtain sufficiently detailed information.

The qualitative research for the HRSA project was conducted during February and March 2001. This document contains a full report of the research findings.

## II. RESEARCH FINDINGS FROM EMPLOYER FOCUS GROUPS AND IN-DEPTH INTERVIEWS

### A. Health Insurance and Employers Today

#### *1. Health Insurance as an Employee Benefit*

Employers were asked to name a variety of compensation methods they view as employee benefits. In every group, health insurance, retirement savings plans and paid time off were mentioned near the beginning of the list. Health insurance is sometimes mentioned as part of a suite of types of insurance, including: life, dental, disability, vision and long-term care. Retirement savings plans were mentioned as 401(k)s and pension plans. Paid time off for employees refers primarily to vacation time, but also includes sick leave, personal time and holidays, such as the Fourth of July.

> *"Health Insurance is so expensive to buy, my employees could not buy it themselves." Not Offering Health Insurance, In-depth Interview*

> *"Everybody's got to have health insurance these days." Not Offering Health Insurance, Brattleboro*

Bonuses, profit sharing and employee stock option programs were also mentioned frequently. Many employers also view raises and flexible working hours as significant benefits. Company-provided or subsidized child care was also mentioned. Many of the groups named employee discounts on products or free products as benefits. Several employers also view unemployment, worker's compensation, social security, Medicare taxes and other required payments, as part of an employee's total compensation package.

A number of groups mentioned that wages, paychecks and raises are benefits of employment. However, there was some discussion as to whether wages were a benefit or a condition of employment. Paying for professional development, including work-related training and development or tuition reimbursements was seen as a benefit. Providing safety equipment, uniforms or a clothing allowance were also benefits. Some employers consider allowing employees to use company facilities, tools and equipment for personal reasons as benefits.

Numerous other types of benefits were mentioned. These included a company car, an expense account or company credit cards, mileage reimbursement, use of a limousine service, a good work environment, company-sponsored events or holiday parties, employee assistance programs for financial loans or emotional support, sabbaticals, family leave, maternity leave, paid parking, health club memberships, wellness programs, massages, ski passes, travel, commissions and the opportunity to telecommute.

*"We offer a ski pass. That is the best benefit I offer. Part-time employees will stick around if they can get a ski pass from you." Small Employer, Offering Health Insurance, Brattleboro*

Some employers feel that allowing employees to choose which benefits they would like to have through a cafeteria plan was a benefit in itself. Among those who do not offer health insurance, one employer indicated that he did not view anything as an employee benefit, because his company does not offer any benefits to employees.

Employers were asked to name the three benefits they see as most valuable, as well as which three benefits they believe their employees view as most valuable. A number of participants noted that the most valuable benefits to offer would depend on they type of company you have and the kinds of employees you are looking to attract.

*"It really depends on the company. If you have older employees, some things are more important to them than younger employees. Younger employees are more interested in the money they can make than they are in the benefits." Small Employer, Offering Health Insurance, Rutland*

Employers indicated that the most valuable benefits to them are health insurance, paid time off and retirement plans. Employers felt that health insurance is more of a necessity than a benefit, because so many employees *expect* employers to offer it. However, there were a few employers who did not consider health insurance as one of the most valuable benefits. Some employers felt that paid time off was a more valuable benefit to them because it costs less to offer and employees value it more than other benefits.

*"Health insurance, incentive pay and retirement plan. From an employer's standpoint, I think those are important." Medium Employer, Offering Health Insurance, Burlington*

*"Health insurance is the primary attractor to put on the table." Offering Health Insurance, In-depth Interview*

Many of the employers who do not offer health insurance said that wages were one of the most important benefits they offered to employees. Small employers who offer health insurance report that good wages are a valuable benefit for them to offer. Some large employers who offer health insurance also mentioned wages as one of the three most valuable benefits they offer. Flexible work schedules and bonuses, profit sharing or performance incentives were also benefits that employers felt were valuable to offer.

*"With a lot of people I talk to, the first thing they ask in the interview is, 'Do you have any benefits?' I kind of cringe when I've got to tell them, 'Yeah, the benefit is that your paycheck is going to clear on Thursday.'" Not Offering Health Insurance, Burlington*

Employees, they believe, value paid time off more than they value health insurance. For employers whose workforces consist primarily of low-wage workers or young workers, many believe that their employees prefer higher wages over health insurance. However, most

employers said that health insurance would be one of the most valuable benefits to their employees. Many agreed that employees find health insurance a valuable benefit; but often not valuable enough to spend a significant amount of their own money on it. Some type of retirement savings plan was seen as the third benefit that employees value most.

> *"I'd want them to have health care, 401(k) and life and disability. Those are the things I feel they should have on themselves but the first thing they ask is what they are getting paid per hour and how many weeks paid vacation." Medium Employer, Offering Health Insurance, Newport*

> *"A younger employee couldn't care less about health care. They'd much rather have the money instead." Not Offering Health Insurance, Burlington*

> *"[Vital benefits to employees are] medical and dental. Dental is just the icing on the cake, but medical is the first." Not Offering Health Insurance, Rutland*

> *"One of the first things a new hire asks is, 'When am I getting my medical benefits?'" Large Employer, Offering Health Insurance, Brattleboro*

Other benefits employers believe employees value are bonuses and/or profit sharing plans and flexible working hours. Employers in every type of focus group, except medium-size employers who offer health insurance, believe wages are the benefit employees value most.

### 2. Employer Attitudes Toward Health Insurance

Employer attitudes toward health insurance differed little among the different groups. Whether currently offering health insurance or not, and regardless of size, most employers agree that offering health insurance is the *"right thing to do."* They are, or would be, happy to offer it; but nearly all employers expressed significant frustration with the state of health care today and concerns about the future of health insurance.

Almost all employers not currently offering health insurance said they would *like* to be able to offer it to their employees. They felt that if they could offer health insurance, their businesses would be more successful than they currently are. Also, they believe that offering health insurance would give them and their employees the peace of mind that they would be taken care of in the event of a major medical emergency. Many feel guilty that they can not fulfill what they see as a social and moral obligation to take care of employees.

> *"The happiest part of a business offering benefits is that it means it is a successful business." Not Offering Health Insurance, Burlington*

> *"I'd like to be able to offer it." Not Offering Health Insurance, Bennington*

Those who currently offer insurance are very happy to be able to offer it and are proud of the health benefits they have available. These employers believe they are fulfilling a social responsibility and are *"taking care of"* their employees. They feel that by offering health

insurance they are keeping their workers happy and healthy. However, a number of employers feel that they *have to* offer health insurance and that they are *"trapped"* into continuing to offer it. One participant labeled offering health insurance a *"necessary evil."* Some who offer it feel guilty because they would like to be able to *"do more,"* such as offer insurance to more employees, provide better coverage or reduce the cost burden on the employee.

> *"We are proud to have it available to the staff." Large Employer, Offering Health Insurance, Rutland*

> *"Half of our people who are eligible for health insurance actually have it. [I am frustrated that] employees don't have the coverage they deserve. The company can't afford to pay for it anymore. We can't increase the company's portion of what we pay, but then we have people dropping off coverage left and right because they can't afford it." Large Employer, Offering Health Insurance, Burlington*

Both those who do not offer health insurance and those who do share similar concerns and frustrations regarding the benefit. The first and foremost concern -- and a reverberating theme throughout all of the discussions -- is the cost of health insurance. Those who are not offering health insurance simply do not know how they could possible afford to offer it – from both a financial and logistical standpoint. Not only does their bottom-line prohibit offering health insurance, they feel they do not have the time or personnel to be able to offer it. All those who currently offer it emphasize that it is becoming harder and harder to afford every year.

> *"It is the right thing to do, but . . . Where do I get it? How do I pay for it? How do I hold onto it? Who administers it for me?" Not Offering Health Insurance, Burlington*

> *"I believe you should take care of you employees, its just the cost. If we could do it, we would." Not Offering Health Insurance, In-depth Interview*

All employers expressed anxiety and frustration over what they perceive as significant fluctuations in the cost of health insurance from year to year and instability in the insurance marketplace. Many employers believe that Vermont's insurance market is volatile. Double-digit increases in premium costs make health insurance an expenditure that is nearly impossible to predict, plan and budget for. Health insurers themselves have been leaving the state, merging or changing benefit definitions so frequently that employers feel there are no guarantees an insurer or plan will be there for them in the future. Small businesses are most vocal regarding their concerns in this area; however, large businesses are also frustrated with the number and swiftness of changes.

> *"You might set out to offer it, but you don't know what your costs will be when you're down the road two or three years from now. You don't know if you will be able to continue because there is no guarantee of what it will cost." Not Offering Health Insurance, Rutland*

> *"With the instability of insurance companies that are available here, too. I mean it is a considerable amount of time to try and pick a health care plan. And to go through this*

*whole thing and then in two years have to re-evaluate a whole other plan. . . I wish you could pick an insurance company that was going to stick around for the next 10 years and be somewhat stable in their plan." Large Employer, Offering Health Insurance, Brattleboro*

*"The other thing is, [insurance companies] are always changing. So you get a plan in place and then everything changes a year later. So, if you offer it, then all of sudden you don't offer it, you'll have a bunch of employees that will be really upset." Not Offering Health Insurance, Burlington*

This perceived volatility and lack of competition, combined with the sense that employees demand employers offer health insurance, leaves many employers feeling angry and unable to control this aspect of their business. There is a feeling of resignation, *"What can I do about it?"* There is a strong sentiment that insurance is too expensive and benefits too limited. Insurers do not feel they have to provide good service because there are so few to choose from. Many small employers believe that large companies are given preferential treatment by insurers, both in the realm of customer service and in the premiums they are charged.

*"I get so angry. It literally makes my hair stand on end. I feel ripped off. I feel helpless. It is either something you can't afford or nothing. And you can't afford to have nothing." Small Employer, Offering Health Insurance, Bennington*

*"How much is that insurance and that is all I get for it?" Large Employer, Offering Health Insurance, Rutland*

*"Because we are in Vermont, we don't have the ability to change because there are only one or two health insurance companies we can go to." Small Employer, Offering Health Insurance, Rutland*

The attitudes of health insurance companies and their customer service also makes many employers irate. Smaller employers, including many of those who do not offer health insurance, feel that insurers are not concerned about them and do not need their business. Many employers believe that the health insurance company they choose reflects on them as an employer. If the customer service is poor or the benefit package is inadequate, employees will think less of them as employers. Many believe that there is little competition among insurers in the state, leading to insurance monopolies and poor customer service.

*"The employees look at us through the eyes of the insurance company that we've chosen and what we've done, and if they see us poorly that increases the turnover rate for us -- we can't afford that." Medium Employer, Offering Health Insurance, Newport*

Overall, but particularly for small businesses, employers stated that health insurance is not very high on the businesses' or employees' priority scale; paying the rent, meeting payroll (including the *"must-pays,"* such as social security, Medicare, unemployment and worker's compensation) come before health insurance. For some, health insurance does not add value to their business in the same way that investing in a new piece of equipment does. For others, their employees do

not need much medical care, obscuring the value of having health insurance. Employees need to pay their rent, utilities, auto payment, car insurance and grocery bill before they consider health insurance. Employers stated that if more employees insisted on health insurance, more employers would offer it.

> *"Considering that essentially 25 percent of your gross income is going away because of taxes . . . what percentage after that is going to go away for health insurance? It is usually pretty significant. And I think in terms of my rent, which is also fairly significant and it almost comes down to a question of rent or insurance." Not Offering Health Insurance, Brattleboro*

> *"We cover our employees 100 percent on health insurance -- and I'm happy to see them have insurance -- but it is a big expense to the company and you cannot recoup it." Medium Employer, Offering Health Insurance, Newport*

A few employers pointed out that health insurance is no longer *"insurance as it used to be,"* meaning it has evolved from financial protection against a major illness or hospital bill into something that employees expect will pay for all of the medical treatments they desire.

> *"I think that we have been spoiled by thinking that insurance should cover everything we want out of medicine when that isn't what it is supposed to be. Insurance should be: you pay for your basic costs, and if they get out of hand insurance will keep you from going bankrupt." Not Offering Health Insurance, Brattleboro*

Plenty of employers who participated in the groups were misinformed about various aspects of health insurance. One insurer mentioned that insurance companies would not offer health insurance to a person who makes $7 or $8 an hour; another reported that health insurance is more expensive for people over the age of 65; another stated that half of the people in Vermont were uninsured. Although some are aware of the idea of cost-shifting, many see this as insurers *"abusing the system"* by charging those with insurance more than those without insurance are charged for the same services. One person stated that in Vermont, all you have to do is pick up the phone and call an 800 number to be automatically signed up for insurance whenever you want it. This participant indicated that this insurance would be retroactive; so that if you were in an accident, all you had to do was call on the way to the hospital to be fully covered.

> *"Vermont is full of small employers, and small employers have no bargaining power. So, at least 50 percent of Vermonters are uninsured, because at least 50 percent of them work for small employers." Not Offering Health Insurance, Rutland*

### 3. Health Insurance Benefits and Beneficiaries

Employers who are offering health insurance describe their health insurance benefits in a myriad of different ways. Employers are offering HMOs, PPOs and point-of-service plans, some of which have $5 co-pays, $10 co-pays or $25 co-pays. Deductibles on plans range from zero to $10,000. Generally, health insurance benefits are as unique as each employers' financial situation. Employers who are having difficulty affording a plan tend to tinker with the

deductible and co-pay levels to bring down monthly premium costs. Some of the participants indicated that they offer more than one type of health insurance plan to employees, but most only offer one plan. Many employers reported that between 5 percent and 10 percent of the company's resources are put into health care benefits; a few reported it is 20 percent or more.

> *"It is our third highest cost of doing business behind payroll and raw materials. That is pretty high." Large Employer, Offering Health Insurance, Brattleboro*

Most employers split the cost of health insurance premiums with their employees. The most common split mentioned is around 80 percent employer-paid, 20 percent employee-paid. A few employers offer health insurance at 100 percent employee cost. Some employers are paying all of the premium expenses for their employees. Generally, the more an employer covers of the premium split, the larger the reported proportion of employees who accept the health insurance. Employers also indicated that they are more likely to cover a higher proportion of an individual employee premium, and a lower proportion, or none of the expense, for any family members brought onto the insurance.

> *"We ask an employee to contribute 25 to 30 percent and then the company picks up the bulk of it. But it is getting to be a big chunk of change." Large Employer, Offering Health Insurance, Rutland*

> *"If we did not pay for 70 percent of the premiums, our employees would refuse the insurance." Medium Employer, Offering Health Insurance, Burlington*

Nearly all participants offer health insurance to their full-time employees; however 'full-time' is defined differently from organization to organization. Some participants reported that more than 17½ hours a week qualifies as full-time; for others full-time is defined as 30 or 35 hours a week. Generally, around 20 hours a week or more is considered full-time. A few employers mention they offer insurance to all their employees. For most, this is because they do not have any part-time employees; for a few, this is because they offer insurance to part-time as well as full-time staff.

> *"Usually [my determination of who is offered health insurance] is based on the insurance companies. They usually set the rule as a standard minimum of 30 or 32 hours. It is coming from the insurance companies." Medium Employer, Offering Health Insurance, Burlington*

Employers had several reasons for not offering health insurance to part-time, seasonal or contract workers. Many indicated that they cannot afford to offer it to everyone, or that the employees do not make enough to cover their share of the premiums. Some indicated that insurance company regulations state that employees must work a specific number of hours to be eligible; therefore, they believe they cannot offer it to those who work fewer hours. Employers also felt the administration of benefits for these workers would be too complicated. Complications would arise from high turnover or the fact that there would be times when a worker would not have a paycheck, or may not earn enough in a given pay period to cover their part of the health insurance premium. Employers felt it would be difficult to collect the employee's share of the

premiums. Others believe offering health insurance rewards those willing to commit to a full-time work schedule and would not want to offer it to part-timers. A few employers indicated they specifically had not hired any full-time employees because they did not want to be responsible for offering benefits.

> *"If they are not regularly scheduled and there is premium-sharing that occurs, it becomes very difficult to administer, quite frankly. The person may be a per-diem employee and may not work every pay period." Large Employer, Offering Health Insurance, Burlington*

> *"I have a part-time employee who is not covered at all, basically because I don't let that employee work that many hours." Small Employer, Offering Health Insurance, Bennington*

> *"I could offer them health insurance through our group, and then they'd have to pay the premiums, which would be $150 a week. They don't make that much!" Small Employer, Offering Health Insurance, Bennington*

> *"You have to go over 32 hours to offer the insurance." Medium Employer, Offering Health Insurance, Burlington*

For the most part, employees who do not accept employer-offered health insurance or are not offered the insurance are covered under a spouse's plan or a state-subsidized plan; some go without health insurance. Some participants said they did not know if their employees had coverage elsewhere or went uninsured. Many guessed that those without insurance tended to be younger, without families to support, or lower-wage earners who could not afford to pay their portion of the split.

> *"The 40 percent who do not accept our insurance go without it. Mostly because they are very young and they don't want to pay a high premium -- which creates a problem because then you don't have enough people to qualify for participation." Medium Employer, Offering Health Insurance, Bennington*

Employers had several different responses to premium increases; however, their initial responses were often, *"We suck it up and pay it,"* or *"Get out the checkbook and write a check."* Some do just that. However, many first respond to the question by asking, *"What can we do about it?"* Employers indicated that, in the past, they would simply change to a different health insurance provider, but feel this is not an option in the current insurance market. They still attempt to compare prices among insurance products, but believe this is no longer a productive solution to finding more affordable coverage. Most commonly, employers reported that they increase the deductible level or the co-pay. Sometimes they change the proportion of the split, so that employees have more responsibility for the premiums. Others mentioned that they change the amount of raises employees are receiving, cancel bonus programs or otherwise reduce company expenses. Some have changed the eligibility requirements for the plan or reduce the number of employees they have. A few indicated that they increase charges to the consumer. A very few report they consider dropping health insurance as a benefit.

*"The company is trying to absorb the majority of the rate increases just to keep the employees in the plan, but there has to be a limit there, too." Large Employer, Offering Health Insurance, Rutland*

*"Sometimes we go to a different plan. Sometimes we see if the employee can do more on the deductible or co-pay." Medium Employer, Offering Health Insurance, Bennington*

*"If it continues to go the way it is, I'll probably start covering a percentage of it instead of the whole thing." Small Employer, Offering Health Insurance, Brattleboro*

Among employers who currently do not offer benefits, a few have offered benefits in the past. Employers give two main reasons for no longer offering coverage – the employer could no longer afford the premiums, or the employees could no longer afford to pay their share.

*"I offered health insurance before, when you could do it based on your group. I had all young, healthy people and it was very affordable for us. But when it changed and everybody got dumped in the pool, it tripled and I could no longer afford it." Small Employer, Offering Health Insurance, Rutland*

*"I carried health insurance on myself for several years and dropped it because of cost" Not Offering Health Insurance, Bennington*

Some employers have tried to implement a health insurance program at their companies. Upon researching plans they found that they could not afford to go through with it, or they found that they did not have enough employees willing to sign up to be able to meet the eligible employees requirement. Many employers have not seriously investigated plans, they simply believe they could not afford to offer a plan – either because the company could not afford the expense or because their employees would not be able to afford to pay their share.

*"We have looked at offering it, some of our employees were just too damned tight to pay the 50 percent of the plan. So, since as a company we had to have 75 percent of everybody eligible in order to be accepted, we did not have enough people interested." Not Offering Health Insurance, Burlington*

*"Cost. That is the only reason why we don't even offer it to ourselves." Not Offering Health Insurance, Bennington*

Many small employers believe that should pay 100 percent of the cost of the premiums or that they should at least pay 80 percent to offer a significant benefit to employees. The general consensus was that offering less would defeat the purpose of an employee benefit, or that employees would not be able to afford to pay more than 20 percent of premiums. In this case, the employers they not have enough eligible employees willing to sign up for the benefit.

*"Asking [employees] to chip in is kind of like asking them to do you a favor." Not Offering Health Insurance, Rutland*

Similar to those who turn down employer-offered coverage, employees of companies that do not offer health insurance are a mix of those who have spousal or state-sponsored insurance coverage and those who go without health insurance. Employers felt that most of the uninsured tended to be young and healthy or low-wage earners; others go without insurance because they prefer to seek alternative treatments not covered by traditional health insurance.

> *"Some are uninsured, some are covered by the state or their spouse. If they are healthy, they don't care, they just go to the ER." Not Offering Health Insurance, In-depth Interview*

## B. Motives for Employer Decisions on Offering Health Insurance

### *1. Why Employers Choose Not to Offer Health Insurance*

Employers who are not offering health insurance are unanimous in their initial response to being asked why they do not: *"COST!!"* Many employers had a hard time moving past cost to discuss other reasons for not offering health insurance. Breaking down the idea of cost into specific elements even proved challenging for some participants.

> *"There is only one reason. That is it." Not Offering Health Insurance, Rutland*

> *"Cost, cost, cost." "That is the only reason why . . . we don't even offer it to ourselves." Not Offering Health Insurance, Bennington*

> *MODERATOR: "I know you've said cost, but I want to break that down. There must be different elements of cost." PARTICIPANT: "Dollars and cents." Not Offering Health Insurance, Brattleboro*

In employers' minds, every reason they do not offer health insurance is, in some way, related to the expense of health insurance. However, when pressed to deconstruct *"cost"* as a reason not to offer health insurance, employers can identify several aspects of cost. These aspects include the premium cost to both the employer and to the employee; the rising cost or unpredictability of what a plan will cost in the future; and the time it would take to research plan options or to administrate a plan for employees. (*NOTE: Elements of cost are discussed in-depth in the following section, Barriers to Providing Health Insurance to Employees.)*

Many employers stated that another reason not to offer health insurance is that employees do not appreciate it. Many said that employees would rather have an increased amount of money in their paychecks, rather than be offered health insurance. Others felt that employees do not understand the true cost to the employer offering health insurance and, therefore, employees do not value health insurance as much as employers think they should. Still others said that employees do not value health insurance because they do not necessarily use health care services.

*"Cost to the employer versus perceived benefit from the employee. If an employer were to pay full health insurance at the cost of $400 a month, the employee would probably rather have $100 more a week in pay." Not Offering Health Insurance, Burlington*

*"They don't know what it costs, they don't think about what it costs and they don't care what it costs, really." Not Offering Health Insurance, Rutland*

Employers also expressed a fear of committing to offering health insurance in the current marketplace where insurers are changing and prices are rising. Some are afraid to commit because it might threaten the stability of their own business. Employers worry that if they were to adopt a plan, the insuring company might leave the state or change the benefits offered, or the cost would rise so significantly that they would no longer be able to afford the plan. Some are worried that their business would experience a downturn, and they would no longer be able to afford the insurance. Others are concerned that if they offer health insurance and then have to drop coverage, employees will be very upset and possibly leave the company.

*"There is no security in a plan. You sign up today, and it could be gone tomorrow." Not Offering Health Insurance, Burlington*

*"[When you don't offer insurance] You don't have to worry about taking something away from an employee. Because of all the fluctuations we've discussed, the rates go up and now, and all of a sudden you either have to ask your employees to pay more or pay a portion, or the carrier goes out or a different one comes in and the benefits change. You always have to deal with the employee and causing him ill feelings when it has nothing to do with your company . . . it an outside influence that is out of your control." Not Offering Health Insurance, Burlington*

Some participants reported that one reason they do not offer health insurance is because their employees don't need health insurance; they are covered under spousal plans, parental plans or state-sponsored plans. A few indicated that they don't offer it because employees do not demand health insurance, or they have yet to experience significant recruiting difficulty.

*"Our employees don't really have a need for insurance or want it." Not Offering Health Insurance, In-depth Interview*

*"Obviously, if there was no way to attract an employee unless you had health care, you'd find a way to provide it, or else you would not have employees. It definitely plays into it. If people will work without having health care benefits, of course people are going to hire them and not give them benefits." Not Offering Health Insurance, Rutland*

Others do not offer health insurance because they experience high turnover in their workforce or their employees are part-time, seasonal or contract workers. With these types of employees, as mentioned earlier, employers feel it would be too difficult to administer a health insurance plan. This is because these workers are often not long-term employees, or because some weeks they may not earn enough to cover their share of the premiums, making collection difficult. Some employers don't offer health insurance because people can access health care without having

insurance – for some this means their claims are covered under worker's compensation or they can simply go an emergency room and be treated.

> *"You can go down here to the emergency room at the hospital and they have to take you and treat you, whether you can pay or not." Not Offering Health Insurance, Bennington*

For some employers, researching plans and comparing different companies is an overwhelming task. While most indicated that the actual work of administering a plan would not prevent them from offering health insurance, many reported they simply do not have the time. Most are aware that there is information comparing plans available, but employers feel it is too difficult to track down. Employers indicated that each insurer writes their information slightly differently, so it is nearly impossible to compare what each is offering. A few employers indicated that health insurance would just be more paperwork, and they already feel that they have to fill out too much paperwork on behalf of employees.

> *"These days [administration] is a pretty minimal factor [in offering health insurance] with computers and such." "[For me,] this is possibly more of a factor than cost. The amount of paperwork I have to fill out for my employees now is huge!" Not Offering Health Insurance, In-depth Interview*

Some employers believe they do not have enough employees to be able to get a plan; most believe they do not have enough employees to be able to get a reasonably priced plan. Some believe that they will not have enough eligible employees willing to enroll in a health plan, making the company ineligible. Another reason not to offer insurance is that employers cannot afford a plan which their employees would want to participate in – affordable plans have too many out-of-pocket expenses to be affordable for employees.

> *"In most of these plans, if you offer coverage, in order to get it, a percentage of your employees have to take it." "So if 51 percent of your employees are covered by their spouses, you can't offer it to the others." Not Offering Health Insurance, Brattleboro*

> *"The level of care offered, too. The plans you can afford don't offer anything worth having, you may not be able to get a level of care that you want. So why bother to settle for something less." Not Offering Health Insurance, Bennington*

A few employers indicated that all the money they have that could go into health insurance goes into those things that employers must pay on their employees – workers' compensation, unemployment insurance, Medicare and social security. A few others said they do not offer health insurance because it is not a requirement.

A few participants indicated they believe the money they could use for health insurance is better used in other ways. Some view health insurance as a *"liability"* that would tie up too much of the company's cash flow. One participant confessed that one reason they do not offer health insurance is they are *"greedy"* – finding the money to afford health insurance would diminish the company's profits.

One of the major benefits of not offering health insurance is that it allows employers to stay in business, meet their payroll and pay their rents. Employers feel that they are saving money, and have less hassles and worries than employers who do offer health insurance. Among things they do not have to worry about are employees who get upset when the benefits change or the cost of insurance goes up. Employers also feel their business is more competitive because they can pay employees more and can invest their money in the business in other ways.

> *"Staying in business. Meeting payroll. Let's be basic about it." Not Offering Health Insurance, Brattleboro*

> *"It maybe makes you more competitive [not to offer health insurance]. If I'm not giving health benefits it means that I don't have to charge that extra to my clients so I am more competitive." Not Offering Health Insurance, Rutland*

The drawbacks to not offering coverage center around recruiting and retaining employees. Employers who do not offer health insurance feel that applicants for jobs with their companies are somewhat different from the people who apply for jobs with benefits. They feel they are only attracting employees who don't need health insurance because they are covered by a spouse or do not care about whether or not they have health insurance. Some employers believe employees will use a job without insurance as a *"stepping stone"* to get experience so they can move on to a job that offers benefits. Some believe that employees have a more negative view of employers who do not offer health insurance.

> *"You don't get a lot of people who want to work for you." "People will leave your job and go get a job where they can get benefits. That is a huge issue." Not Offering Health Insurance, Bennington*

Another drawback is being exposed to the risks uninsured people take. Employers recognize that their uninsured employees may put off preventative care, which can lead to prolonged absences. They recognize that their businesses do not run as effectively when key employees are out sick. They also recognize that they could lose an employee to a major illness, or that an employee (or themselves) could be financially devastated by a long, expensive illness.

> *"[A drawback is the possibility of] a tremendous tragedy, having something terrible happen to them and not having coverage." "And not getting help when they could have because they could have stopped the tragedy of death had they gone to the doctor and had it looked at and taken care of." Not Offering Health Insurance, Brattleboro*

### 2. Why Employers Choose to Offer Health Insurance

Nearly all employers who offer health insurance report that one of the main reasons they do so is to be competitive in employee recruitment. Employers believe that by offering health insurance, they can attract and keep good employees. Employers who offer insurance believe that the job applicants they have to select from are of a better quality than the applicants who apply at companies that do not offer health insurance.

*"You have to [offer health insurance] to be competitive." "To attract high-tech and highly skilled people." Large Employer, Offering Health Insurance, Burlington*

*"[We offer insurance to] retain and attract employees for the long-term." Offering Health Insurance, In-depth Interview*

*"Recruitment and retention. I know of situations where people interviewing for jobs don't even ask what the salary is, they just want to know what the health insurance is." Small Employer, Offering Health Insurance, Bennington*

Many view offering insurance as protecting the investment they make when hiring and training employees -- a part of the compensation package that helps instill loyalty in employees. Some employers said they offer health insurance because they feel they must in order to fulfill employees' expectations.

*"If I did not offer health insurance my guys would be down the road." Small Employer, Offering Health Insurance, Brattleboro*

*"It is almost an essential recruiting tool today." Large Employer, Offering Health Insurance, Brattleboro*

Some employers offer health insurance because it is one way to increase the value of employment without offering higher wages. Others feel that health insurance increases the total compensation package, thus increasing the total wages of an employee. A few said that offering health insurance is a way to increase wages without increasing the tax burden on employees.

*"A lot of people say the wage scale is lower in Vermont. So the health insurance helps make up for that." Offering Health Insurance, In-depth Interview*

*"We started offering it because it was a tax-free way to get coverage for both the employee and employer." Small Employer, Offering Health Insurance, Bennington*

Another reason to offer health insurance is that employees with health insurance are healthier employees. With access to health care, they can afford to have illnesses treated. Employers believe that healthier employees are more productive employees. Employers also believe that by offering health insurance, they are offering their employees *"peace of mind"* and giving them the feeling that they will be taken care of if anything should happen. Health insurance offers financial protection and security as well. Employees are less likely to be distracted from work if they, or a family member, become ill because they know health insurance will take care of them. Offering health insurance is also seen as a way to reward employees and as something that contributes to good employee morale.

*"They are happier and healthier. So are their families. They come to work more." Offering Health Insurance, In-depth Interview*

*"I think that [offering health insurance] increases productivity. I think that if folks are worried about things, they don't perform as well. And I think if they are sick, obviously, they not going to either." Medium Employer, Offering Health Insurance, Burlington*

*"A healthy employee is going to produce more than an unhealthy employee." Large Employer, Offering Health Insurance, Rutland*

Finally, some participants indicated that the company offers health insurance for selfish reasons -- so that they, themselves, have access to health insurance at group rates or because the owners want health insurance for themselves. Many said they offer it because it is the *"right thing to do"* -- they believe employers have a social responsibility to offer health insurance to employees. A few indicated that one reason to offer it is because it makes them look good in the eyes of their employees and the communities in which they operate.

*"I would not work there if I did not offer health insurance." Large Employer, Offering Health Insurance, Burlington*

*"In a small business, you are covering yourself, you are getting some kind of group coverage for yourself, which otherwise, you could not get." Small Employer, Offering Health Insurance, Rutland*

*"It is the right thing to do. Everybody should have it." Medium Employer, Offering Health Insurance, Bennington*

Participants nearly unanimously agreed that one of the major drawbacks to offering health insurance is cost. Other drawbacks include employers' sense that employees do not really value or appreciate health insurance benefits and that the insurance company reflects on the employer, often poorly because they do not offer good customer services.

*"They don't understand the back –of-the-house costs to a company." Large Employer, Offering Health Insurance, Burlington*

*"The biggest problem we see is . . . We want to provide something to our employees that is a benefit to them, that they can feel good about us an employer. But because of the limits on the number of insurance companies available to us, there's no competition. So we get poor service and higher rates. And that is an issue." Medium Employer, Offering Health Insurance, Newport*

Many employers find dealing with insurance companies to be a drawback to offering health insurance. They feel that shopping around for different plans to be very frustrating and the information available to be confusing and difficult to decipher. Many feel their choices are limited because there are few insurance carriers in Vermont. Others indicated plan offerings and health insurance regulations change frequently.

*"With the instability of insurance companies that are available . . .I mean it is a considerable amount of time to try to pick a health care plan." Large Employer, Offering Health Insurance, Brattleboro*

Some employers find that the plans offered today are not flexible enough to meet the needs of employees or the employer. For example, employees cannot choose which benefits they would like to pay for and which benefits they would rather not have, and employers cannot offer several different plans to employees to choose from.

*"It is not flexible enough." Small Employer, Offering Health Insurance, Bennington*

### 3. Events that Would Prompt Employers to Reconsider Offering Health Insurance

While few companies who offer health insurance today foresee a time when they will not offer the benefit to employees, several could see a day when they might need to significantly change the benefits they offer – offering high deductible, high co-pay packages with less generous coverage than they have today. Perhaps not surprisingly, the smaller companies were more likely to report foreseeing a day when they may no longer be able to offer health insurance. Most participants reported that it would take dramatic changes in their situation -- such as a 50 percent premium increase, an economic recession or a significant downturn in their business -- before they would consider eliminating health insurance as a benefit. Some indicated that if premiums continue double-digit rises for the next three to five years, they might have to reconsider. Most agreed that they would continue to offer health insurance regardless of the situation, but the quality of the benefit would suffer. Many felt that if they could no longer afford to pay other bills, they would get together with employees and decide what to do about insurance. They saw, in that case, that if employees did not want to pay a reasonable share, they might have to drop the coverage.

*"We'd go out of business first [before not offering health insurance to employees.]" Large Employer, Offering Health Insurance, Brattleboro*

*"We've thought, 'Do we need to change? Do we need to offer less than we are offering?' We've tried to keep a rich plan in place, but we have started questioning whether we can afford it and maintain the bottom line and invest in the future and the company." Large Employer, Offering Health Insurance, Rutland*

For those not offering insurance today, two main possibilities were cited as foreseeable prompts to adopting a plan for employees – an increase in the company's revenue or more affordable plan options. Employers emphasized that a more affordable plan would have to be one that employees would be attracted to, with elements such as a reasonable deductible and coverage for preventative care. Others mentioned that *"more flexible"* plans that would meet employees' needs without a lot of other coverage options would be more affordable and more enticing to them. A few employers mentioned they would consider health insurance if the government would subsidize the cost for them. One mentioned that moving his business to another state might prompt him to consider offering health insurance.

*"[I would offer it if] there were a better group plan that smaller businesses could fall under, without exorbitant deductibles and with affordable rates." Not Offering Health Insurance, Rutland*

The definition of *"affordable"* rates varied from employer to employer. Employers felt that *"affordable"* would also depend on the coverage of the plan, and the amount of out-of-pocket expenses. Some felt that $200 a month, per employee, would be reasonable; others thought that $150 a month, per employee, for single coverage would be affordable. Many employers said that these amounts would be what they would be willing to pay, so the premium could actually cost more depending on the split the company shared with the employee. Most employers felt that they would have to pay at least 80 percent of the cost, or their employees would not be willing to participate.

*"It would depend on what it is. You can't put a dollar value on it." Not Offering Health Insurance, Rutland*

*"It depends on what kind of coverage you are getting." Not Offering Health Insurance, Bennington*

*"A good employer is going to pick up at least 80 percent." Not Offering Health Insurance, Bennington*

## C. Barriers to Providing Health Insurance to Employees

Employers perceive several barriers to being able to provide health insurance to all employees in Vermont. Again, employers emphasized that cost is a major obstacle. Many of the barriers mentioned by employers are interrelated. As will be discussed below, cost, state regulations and the current insurance market are considered the most significant barriers to expanding health insurance coverage in Vermont. However, employers also recognize other barriers, such as access to accurate and clear information, the nature of Vermont as a small state and a lack of employee willingness to sign up for plans for which they do not want to pay their portion of the cost. In addition to the barriers named by participants, the focus groups revealed that some employers have misconceptions regarding health insurance, which may also pose somewhat of a barrier to their seeking out insurance plans for employees.

### *1. Elements of Cost as A Barrier*

Employers emphatically stated that cost is the major barrier to whether or not a company will offer health insurance to its employees.

*"Cost is 95 percent of the problem." Not Offering Health Insurance, Burlington*

Cost, however, is a multifaceted barrier. Initially, cost is discussed as the bottom-line dollar amount that an employer spends on health insurance every month. Employers also indicated that the cost barrier also involves the amount of money an employee must spend monthly both on

their health insurance and their healthcare. In other words, cost is more than just the amount an employer pays in premiums every month; it also includes the amount employees must pay in premiums, co-pays and deductibles.

In nearly every focus group, employers discussed two reasons they believe cost has become a barrier to offering health insurance in Vermont. First, they believe that state mandates in healthcare -- such as community rating, guaranteed issue, and mandated coverage for mental health and chiropractic -- have increased the cost of plans and made it more difficult for health insurers to make a profit in the state. Many believe that this has led to the second reason that cost is a barrier: that insurers have left the state and there is little competition among those remaining, resulting in higher prices. Both of these issues will be discussed in-depth in following sections.

Many smaller employers also see cost as a barrier because they feel that to be able to have a policy they can afford, the out-of-pocket expenses to employees are so high that employees are not willing to participate in a plan. To them, offering health insurance but requiring significant employee contributions defeats the purpose of offering health insurance as a benefit. Others feel they cannot afford to cover a significant portion of the monthly premium and therefore cannot offer employee health insurance with a *"reasonable"* premium split.

> *"No, they won't take it. They won't spend that little bit of money every week on health insurance." Medium Employer, Offering Health Insurance, Burlington*

> *"Any level [of insurance] that is appealing to an employee is expensive." Not Offering Health Insurance, Bennington*

> *"We are going to go to a 90/10 split, then to an 80/20, then 70/30. Then there will be a point at which you will say, 'We can offer you so little in terms of a health benefit, we will just put the money into your salary instead." Medium Employer, Offering Health Insurance, Bennington*

Employers believe that the actual cost of health insurance versus the perception of its value is also a part of the cost barrier. This element has three dimensions. The first, as mentioned previously, is the employer perception that employees simply do not understand the full cost to the employer who offers health insurance, and therefore, employees do not value the insurance as much as they should.

> *"They don't understand it. They don't see it; they just see the doctor. They know it is paid for so they don't see the cost to the company or what would come out of their pocket if they had no coverage. If they realized that they used thousands and thousands of dollars in healthcare and did not have to pay any of it they might start to realize, 'Hey! This is a good benefit!'" Large Employer, Offering Health Insurance, Burlington*

The second dimension is the fact that many healthy employees do not use the healthcare system frequently. This leads to the attitude that, because they only use a little healthcare over the course of a year, they would pay more in monthly premiums than they would if they just pay for

services as necessary. Therefore many employees are not willing to participate in health insurance plans with significant costs.

> *"When the month is over and you've paid out all that money and you have not gotten anything for it . . ." "You're hoping some employees will get sick or something." Not Offering Health Insurance, Rutland*

> *"The cost of insurance is sometimes more than what you would spend at the doctor's office to begin with." Not Offering Health Insurance, Bennington*

The third dimension is the employer attitude that surfaces in many different areas when discussing cost. Many employers feel that the premiums are so expensive, the level of benefits minimal and the deductibles so high on affordable plans, that it is not worthwhile to offer health insurance as a benefit.

> *"The problem I have is that the premiums are so high and the benefits are so low. If I were to pay 100 percent of the employees' premiums, it would bring us to our knees almost. And yet, the benefit to the employee is marginal." Medium Employer, Offering Health Insurance, Burlington*

> *"The prices are so astronomical, and you've still got this enormous deductible per person So what are you actually getting for that money? Not very much." Not Offering Health Insurance, Rutland*

Another element of cost is the fact that it is nearly impossible to predict how much a plan is going to cost an employer from year to year, much less to be able to include the cost of health insurance in a three- or five-year projection for business expenses. Employers feel that they cannot budget and plan for their health insurance expenses; which makes them wary of getting involved in offering health insurance. Employers noted that there are very few other businesses that can raise the cost of their product as frequently as health insurers do, and there are very few markets that would tolerate the volatility that employers are expected to deal with in health insurance.

> *"You can't control it. It is a cost that I see going up every year." "If I run a business, I can budget my advertising. This is something I can't say, 'Well, I am going to cut back on my health insurance for four months.' It is a given: rates go up. It is like the IRS tax bill, you can't negotiate it, you just have to pay it." "Health insurance is the only thing I deal with that has that much of an economic impact on everything I do . . . but you can't predict it." Small Employer, Offering Health Insurance, Bennington*

> *"I call up and compare fuel prices. I eat at restaurants where I can afford the food. But in healthcare, its like a roulette kind of thing where you just hope." Small Employer, Offering Health Insurance, Brattleboro*

Some employers also see the cost of healthcare as a part of cost as a barrier to offering health insurance. Most recognized that rising health care costs, particularly the cost of prescription

drugs, do play a role in the rising cost of health insurance. A few also feel that insurance fraud and *"abuse"* of the healthcare system (through overuse) is contributing to higher health insurance costs.

> *"People cut themselves and go to the emergency room. That is the most expensive place. I just think the thing that increases health care costs is consumer behavior. It is the biggest driver of health care." Large Employer, Offering Health Insurance, Burlington*

> *"There are some that will go to the doctor far more often than perhaps is necessary. But they feel that they pay for the insurance, it is their right. And they don't feel their behavior is affecting the overall premium." Large Employer, Offering Health Insurance, Brattleboro*

Many mentioned that the cost-shift -- where those who can pay are charged more than those who cannot -- is a significant element of increased health costs, leading to increased health insurance cost. Employers believe that the federal and state government reimbursement rates are contributing to increasing their health insurance costs because the reimbursements are not covering the cost of care.

> *"They pay fifty-two cents on the dollar, but the hospital has to pay the full cost, so it passes it down to those of us who pay for insurance." Not Offering Health Insurance, Brattleboro*

> *"Part of the cost of that $10.00 aspirin goes toward the people who could not pay anything toward that aspirin. As the pool gets smaller of those with insurance, then a smaller percentage are paying for a larger group that does not have it. It's a catch-22." Medium Employer, Offering Health Insurance, Newport*

Some employers indicated that part of the cost equation is the fact that they feel they cannot increase cost of their product or service to be able to cover the costs of offering health insurance. They feel that if they were to raise prices, they would no longer be able to be competitive players in their markets. Others said that they could not afford to pay employees more so that the employee could afford insurance. These employers felt that even if an employer offered insurance and split the monthly premiums with employees, the employer still ends up paying the full cost of insurance because they would have to pay employees more so they could afford the employee-paid portion of the premium.

> *"We are in a manufacturing environment, and you've got to structure your cost. So, if [health insurance] is ever-increasing, your costs are increasing in the company and that makes you less competitive." Large Employer, Offering Health Insurance, Brattleboro*

> *"You can't raise your revenue as fast as the health insurance costs go up." Medium Employer, Offering Health Insurance, Bennington*

Employers indicated they have several things they must pay for each employee (worker's compensation, unemployment taxes, social security and Medicare) that reinforce the cost barrier. They feel they simply cannot afford health insurance too.

> *"We have the 'have-tos,' and then we have the 'bennies.' The 'have-tos,' take 15 percent from gross income for federal and state taxes. Then we have expenses. Add another 13 or 15 percent for workman's comp. That is the reality for a small business owner." Not Offering Health Insurance, Rutland*

Employers see the cost to pay a staff member to administrate a plan as a minor aspect of cost. Most agree administering a plan is part of overall cost burden; however, most also feel that if an employer could afford the cost in terms of the monthly premium, they would also be able to afford administrative costs.

> *"Cost is THE barrier. The administrative cost of offering insurance is trivial to me, in comparison to what I have to pay for the premiums." Not Offering Health Insurance, Burlington*

### 2. State Regulations and the Current Insurance Market in Vermont

Employers believe that state regulation of the health insurance market over the past several years has created barriers to employers being able to offer health insurance to employees. As mentioned earlier, many employers believe that Vermont's regulatory environment has prompted many insurers to leave the state, thus resulting in little competition and higher prices.

> *"The State of Vermont has been so anti-business in this particular area that all of the major insurance companies have dropped out." Medium Employer, Offering Health Insurance, Bennington*

> *"The amount of regulation of insurance that has already happened in Vermont has forced us down to where there are no choices, really. Everybody left Vermont." Large Employer, Offering Health Insurance, Brattleboro*

> *"[A lot of carriers have left the state because] they've been imposed with a lot of restrictions that kind of forced them out." Not Offering Health Insurance, Rutland*

> *"I don't remember what created the whole problem. I know the governor put a lot of restrictions on the insurance companies and that's why a lot of them pulled up stakes and pulled out." Not Offering Health Insurance, Rutland*

> *"I think a big barrier is the state itself. If you talk to insurers, they don't want to come and do business here [because of] the mandates. It is not a friendly state. There is a whole host of other issues that make this state an unpalatable place for insurers to do business." Large Employer, Offering Health Insurance, Burlington*

In the employers' eyes, this creates two barriers –limited choice of health insurance plans, and inability to bargain for better prices among various insurers.

> *"Right now there is no competition left in the state. It is a monopoly. They can charge you whatever they want because if you want it, you're going to pay for it." Medium Employer, Offering Health Insurance, Burlington*

> *"There is just not enough competition. Competition, when you have it in anything, whether it is business or insurance, allows for more choices." Medium Employer, Offering Health Insurance, Newport*

> *"[There is] very limited choice now in what is available, what health plans are available for you to choose from." Not Offering Health Insurance, Rutland*

> *"[A barrier is] lack of competition, which effects cost." Small Employer, Offering Health Insurance, Rutland*

> *"A lack of choice for one [barrier], that's one of the major ones." Large Employer, Offering Health Insurance, Burlington*

To many employers, more insurance companies would mean lower premiums, pure and simple. Even when asked whether or not they believe other factors, such as rising health care costs and utilization, would have greater effect on health insurance cost, many employers insisted that more competition would reduce prices. Some are willing to concede that other factors may help reduce costs, but many feel that increased competition is the key to reducing premium rates.

> *"If you have more grocery stores in a community, you're gonna have better prices than if you only have one. There would be competition. [The health insurers] have no competition." Medium Employer, Offering Health Insurance, Bennington*

> *"I came from California where you had health insurance companies beating on your doors . . . it actually drives costs down." Large Employer, Offering Health Insurance, Burlington*

> *"The marketplace will always deliver. You want the best quality, best service, best price, you go to the marketplace." Small Employer, Offering Health Insurance, Rutland*

> *"Competition is always good. Usually more competition means better deals and lower prices." Not Offering Health Insurance, In-depth Interview*

> *"I think that if there were competition in a real sense, you would not have cost increases of 20 percent plus a year. I don't think that a reasonably run business in the state would have that kind of increase in premiums if there were real competition, because people would go elsewhere." Not Offering Health Insurance, Brattleboro*

*MODERATOR: "Who would agree that it is not competition but healthcare costs; therefore more competition would not reduce rates?" PARTICIPANTS: "It'll reduce it to some extent." "Somewhat." "I agree with that." "It is not going to reduce it drastically." "Competition should reduce costs." Medium Employer, Offering Health Insurance, Newport*

Employers were asked whether their perceived lack of choice was a result of a limited number of health insurance *plans* to choose from or a limited number of *companies* to choose from. Employers were quite clear that lack of choice was a result of too few companies offering health insurance in the state. When pressed as to how many companies they felt should be available for *"enough competition,"* few had a ready answer, though most groups determined that between 10 and 15 insurers would be an adequate number. Many felt that the number of companies was not relevant, that there would be *"enough"* when they could get a reasonable health insurance policy at an affordable rate.

*"I think the number of companies is not as important as the different [types of coverage] that are offered." Small Employer, Offering Health Insurance, Rutland*

*"You will have enough companies in the state when you start hearing of somebody lowering the cost of a plan instead of raising it." Small Employer, Offering Health Insurance, Rutland*

*"We just need one good plan [not necessarily more competition.]" Not Offering Health Insurance, Rutland*

Employers also believe that state regulation, has increased the cost of health care plans because of mandated coverage and the elimination of experience ratings. Many employers felt that in the past, they had been able to benefit from having younger, healthier employees. However, once community rating went into effect, they saw their health insurance premiums rise. Many also associate the introduction of community rating and guaranteed issue with many of the insurers leaving the state.

*"Golden Rule, and a few others, would offer very, very affordable rates to people who did not smoke, did not drink and other characteristics and when they put in this not allowing the cherry-picking, they packed it in. We went from 35 or 40 [companies] down to 10." Not Offering Health Insurance, Brattleboro*

*"The fact that you can't use your own pool now. I mean, sometimes that hurts people, but sometimes it helps them. The fact that we have a very young healthy group . . ." Not Offering Health Insurance, Rutland*

*"In Vermont, it is all guaranteed issue. It is all one price regardless of your age or health. And that is one thing, at least these companies tell me, they're leaving the state of Vermont because they just couldn't afford to deal with the guaranteed issue thing." Medium Employer, Offering Health Insurance, Newport*

Employers also questioned the state mandates for coverage of certain services. Chiropractic care and mental health coverage were mentioned most often; however, many employers also frequently mentioned maternity coverage as a state mandated coverage in health plans. Many felt that these mandated coverage options are not necessary, and that people who do not use those services should not be required to pay for them.

> *"Part of it is the shift from pure medical care to mental health and chiropractic, to guys with beads and rattles who can now get certified. They should be offering policies that do straight medical. If you want alternative medicine, fine. Those are riders or separate policies." Not Offering Health Insurance, Brattleboro*

> *"They had a single guy but he had to have insurance in case his wife had a baby. He's got to pay that insurance, even though he ain't got a wife! Why do you have to have it if you ain't got a wife? It is stupid." Not Offering Health Insurance, Brattleboro*

> *"We had six guys and not one of us was in childbearing age. But we had to carry the maternity benefit. I mean it made no sense whatsoever. If you could say, 'Nobody in our shop is going to take advantage of this, knock off $50 month.' But you can't do that so, regardless, you get charged for all of them." Medium Employer, Offering Health Insurance, Newport*

A few employers recognized that increasing health insurance costs are more complex than recent state regulations or the state of the current insurance market.

> *"I don't think the most cost-efficient insurance company could change it. I think the problem is far deeper than that. I think it is a lack of understanding that there is no population that can afford the healthcare it wants." Medium Employer, Offering Health Insurance, Burlington*

> *"Maybe we need to look at health care costs as well." Not Offering Health Insurance, Rutland*

### 3. Access to Clear and Accurate Information

Employers were asked to comment on the accessibility and sufficiency of health insurance information available to them. Employers agreed that there is information "*out there,*" but feel it is difficult to find, hard to understand and nearly impossible to compare effectively.

> *"It is a lot of work to find out what you can offer. I spent a tremendous amount of time doing this." "They don't make it easy to find." Not Offering Health Insurance, Rutland*

> *"They have got it all worked out so you can't choose. I can put down six choices in front of me and it is bewildering. Because you can't really compare apples to apples. It is comparing every different type of thing, and there is really no way of shopping around." Small Employer, Offering Health Insurance, Brattleboro*

Many employers, particularly small employers, felt that they did not have the time to track down information, sort through it and make sense of it. Many employers expressed that reviewing health insurance information was a very time-consuming process. They lament the lack of a central, independent source of information and the burden of having to search for information themselves. A few indicated that they did not know where to begin looking. Insurance brokers were mentioned as a possible source of information, but many felt they were not a reliable source because they cost money or only represent certain insurance companies.

> *"The information is there if you are willing to spend the time to dig it up yourself. There is no state agency that is going to provide any assistance to you. You can buy the information from a broker." Large Employer, Offering Health Insurance, Rutland*

> *"Where do you start? In the phone book?" Not Offering Health Insurance, Rutland*

> *"There are groups you may get information about; but there is no group that gives you information about all the plans that you can have." Small Employer, Offering Health Insurance, Bennington*

Employers believe that the main source of information on insurance plans available in the state is the insurance companies themselves. They feel that the information from insurers is not clear or concise, and that it is written in *"insurance language,"* which they do not understand. They feel there is no consistency in the way that insurers present their information, making it difficult to evaluate the benefits and drawbacks of what various companies are offering. Most did not consider information from insurers to be a good source of information, because insurers are trying to make a sale.

> *"To try to understand these plans and figure out which is best for us was difficult. They couldn't put it down in A, B, C. They had to have all this kind of mumbo-jumbo stuff." Small Employer, Offering Health Insurance, Rutland*

> *"It does not seem like I can compare apples to apples from one provider to another. Everybody wants to sell you a different policy. So it has been very hard to compare plan to plan. There is no uniformity, no ability to compare one plan to another directly." Not Offering Health Insurance, Burlington*

> *"[Insurers are not a trustworthy source of info because] they are out to sell their products." Small Employer, Offering Health Insurance, Bennington*

Other employers believe that there is not enough information about the rules and regulations around offering health insurance for employers.

> *"I think it is very complicated. Insurance is very scary to a lot of people because there are so many innuendoes, just like tax law. You know, there is no way that we can fully understand it. We are going by what we are told and what we understand." Not Offering Health Insurance, Brattleboro*

Smaller employers feel they do not get information unless they ask for it. There is a sense that insurance companies paid more attention to larger employers – sending them information, offering them better rates and generally trying to woo their business. Some small employers felt that insurers are not really interested in courting their business.

> *"For big businesses, yeah [there is enough information]. Smaller businesses are busy enough trying to run a business and no one is calling them." Offering Health Insurance, In-depth Interview*

Employers are aware that the state provides information about health insurers; however many said the state only provides very general information, such as which insurance companies are operating in the state and their phone numbers. Some feel that the information provided by the state does not always provide them with all of their options.

> *"I called the state, or whomever, and I got this list, and later I find out about this other company that was not on the list. I think that there are probably more options than we are aware of, but that information is not readily available." Small Employer, Offering Health Insurance, Rutland*

When discussing the need for an unbiased source of information on health insurance plans available in the state, a few employers felt that this responsibility should fall on Vermont's Secretary of State or the insurance commission.

> *"I would assume that the insurance commission would do that." Medium Employer, Offering Health Insurance, Newport*

Participants indicated that they would like to make use of an independent, unbiased source of information, one that would be proactive in disseminating information to employers. Participants would like a source of information that would seek to standardize the available information so that they could make comparisons from plan to plan, company to company and decide which would best suit their needs.

> *"I would like someone who has no financial interest in that transaction to tell me what is missing from the policy." "Kind of like a guarantee report on insurance." "It should be the state." Not Offering Health Insurance, Bennington*

> *"What I would like to see is a chart that would have what each plan is, very simple, in simple English, which one offers what." Small Employer, Offering Health Insurance, Rutland*

Possible methods of distributing information might include posting it on a Web site, holding daylong seminars across the state for employers and contacting employers to discuss their options with them. Others thought there should just be a source employers could call that would have information readily available for them.

*"It would be great if they had a Web page that told you clearly what the benefits were going to be." Small Employer, Offering Health Insurance, Brattleboro*

### 4. The Nature of Vermont

Another barrier mentioned by several employers is simply the fact that we are in Vermont. Some feel that the small population of the state means that the economic potential for businesses to make enough profit to afford health insurance is low. A small population also precludes competition among insurers. Others feel that Vermont offers lower wages than other areas, leaving Vermonters without the resources to purchase insurance. The fact that there are so many small businesses in Vermont is also part of the equation. Many employers feel that small businesses do not have leverage to negotiate premium prices, and, therefore a number of Vermont businesses cannot offer health insurance. Finally, some said that because Vermont is a rural state, insurers have difficulty negotiating networks and provider discounts.

Some employers feel that Vermont's small size and relatively small population base make it difficult for businesses to thrive here. Many of the state's businesses struggle to get by and do not have the capital to invest in health insurance for their employees.

*"There is not enough of a population in Vermont to support businesses, therefore, businesses do not make enough to provide decent salaries and offer health insurance." Not Offering Health Insurance, In-depth Interview*

*"[A barrier is] economic potential for business in Vermont. If you want to make money you don't really come to Vermont." Small Employer, Offering Health Insurance, Bennington*

Others feel that the small population of Vermont makes the state unattractive to health insurance companies. Others feel that because there are so few people in Vermont, Vermonters are charged higher rates than people in other parts of the country. Finally, a few employers said that the small population combined with the state's regulatory environment, had convinced many employers that Vermont was not worth their investment.

*"Insurers love profit. Where can they get the most profit? Where there are more numbers of people. So I am asking, are we the victim of sparse population?" Large Employer, Offering Health Insurance, Rutland*

*"Population. We are too small a pool to get a decent rate. The size of the state." Small Employer, Offering Health Insurance, Bennington*

*"A lot of carriers have left the state because there's not enough dollars. We've only got a half a million people." Not Offering Health Insurance, Rutland*

*"The government control would work in a state the size of California, and unfortunately Vermont is not. Insurance companies would put up with the rules and regulations because there is a vast market. We have such a small percent of the national population*

*that as soon as these regulations came down from government these companies just left because there was not the market to drive them to put up with the regulations." Medium Employer, Offering Health Insurance, Newport*

Many employers pointed out that Vermont has a high proportion of small businesses. They felt this might be a barrier because they believe that small employers are charged higher premium rates than large employers. Many stated that small employers lack the bargaining power of larger employers and, therefore, can not negotiate for affordable health insurance plans.

*"I think the difficulty in Vermont is simply size. It is based on the size of the people you bring in, and that gives the company the ability to negotiate the cost." Large Employer, Offering Health Insurance, Burlington*

*"Prices do come down in groups." Not Offering Health Insurance, Rutland*

*"[A barrier is] no bargaining power. It's just the vast number of small employers." Not Offering Health Insurance, Rutland*

A few employers pointed out that employees earn lower wages in Vermont than in other areas of the country. For many, buying insurance is beyond their resources. Another wage-related barrier employers identified is that some people in Vermont only work enough hours to be able to get by and do not have a lot of disposable income, or they work several part-time jobs and none of the employers offer health insurance to part-timers.

*"The level of wage stinks." Not Offering Health Insurance, Brattleboro*

Finally, a few employers mentioned the rural nature of the state is a barrier. Many communities in Vermont have a small number of healthcare providers, making it difficult for insurers to form competing networks to negotiate price breaks. Additionally, for employers who have employees spread across the state, it is difficult to find a health plan whose provider network satisfies the needs of all employees. Other problems related to the rural nature of Vermont is that practitioners in rural areas may not be included in insurance company networks; therefore, the plans available to an insurer may only cover practitioners that are too far away for people to go to.

*"We have this unique situation in Vermont where every community has one community hospital. There is very little competition amongst hospitals. The insurers who are contracting with hospitals, they don't have much leverage." Large Employer, Offering Health Insurance, Brattleboro*

### 5. Other Barriers

As mentioned in previous sections, employers identify employees themselves as a barrier to being able to offer health insurance. Employers have experienced situations where employees are not interested in joining employer-sponsored plans because they cannot afford to pay their

share of the premium, they are covered by another plan or they simply would prefer to have the money instead of the benefit..

> *"We have people dropping our health insurance because they can't afford it any more. The smaller income levels, the people that are younger, might have small children, families, it is too much out of their paycheck to afford the premium." Large Employer, Offering Health Insurance, Burlington*

> *"It is that invincibility complex." Large Employer, Offering Health Insurance, Brattleboro*

> *"What frustrates me, we charge $250 a month for family coverage, nothing for the single employee. Our people are pretty well-paid. It is amazing to me how many people do not cover their kids because they don't want to pay $250 a month." Large Employer, Offering Health Insurance, Brattleboro*

> *"I have one guy right now who won't spend $20 a week." Medium Employer, Offering Health Insurance, Burlington*

For some employers, a lack of employee willingness to join their plan creates another barrier which insurance companies should address. Employers cited *"insurance company rules"* that require a minimum percentage of *"eligible"* employees to sign up as being an issue in maintaining benefits for their employees.

> *"They require that you have a certain percentage of the eligible employees. If you had enough employees that weren't interested in it for one reason or another . . . So you can't get the 75 percent and that can become a barrier also." Medium Employer, Offering Health Insurance, Newport*

> *"The health insurance company's regulations themselves [can be a barrier]. We talked about why we don't offer insurance to people who work 17 ½ or 20 hours? Because you have to have 75 percent of your eligible employees enroll. Most of your 20-hour employees can't afford it, so they will turn it down. So you can't even offer it to them." Large Employer, Offering Health Insurance, Rutland*

> *"Some insurers will not insure your group unless you can offer a certain percent of your group. That is a barrier." Medium Employer, Offering Health Insurance, Bennington*

Some view the lack of flexibility in the plans that insurers offer as a barrier. Employers suggested that if insurance companies were more flexible in putting together plans, it would be easier to find an affordable plan that would be still be attractive to their employees. Still others believe that if employers had more flexibility in designing plans relevant to the needs of their employees, it would be easier for employers to offer insurance.

*"When you select what you want, you can't have different deductibles for different employees. You can only have one deductible and everybody has to stick with that." Small Employer, Offering Health Insurance, Rutland*

*"It is not flexible enough." Small Employer, Offering Health Insurance, Bennington*

One employer saw an aging workforce as a barrier to providing health insurance, indicating that older employees increase the cost of health insurance.

*"An aging workforce is going to increase your costs." Large Employer, Offering Health Insurance, Burlington*

A few employers believe that the time and money spent administering health insurance is barrier; however, most employers perceive of this as a minor distraction rather than a barrier to offering the benefit.

*"It pulls away from your office staff. Whether it is trying to find a better mousetrap or just dealing with the paperwork and complaints." Medium Employer, Offering Health Insurance, Newport*

*"I would think that would be the least of my problems." Not Offering Health Insurance, Brattleboro*

Finally, although not specifically mentioned by participants as a barrier to offering health insurance, it is clear that some employers do not fully understand certain elements of offering health insurance. Those who do not currently offer health insurance were asked to answer a series of questions, true or false, about current regulations regarding employers and health insurance.

Most employers who are not offering insurance know that their portion of health insurance premiums are tax-deductible, and that insurers cannot deny small businesses access to health insurance because of the health status of employees. However, more than a third of those who answered the questions did not know these to be true.

About half of those asked thought that health insurance premiums are treated less favorably than general business expenses on tax returns or that there is no limit to the amount an insurer can charge an employer who has sick workers. Finally, many employers do not believe it is possible for them to spread the cost of a sick employee over a large pool of workers.

## D. Responsibility for Insuring Vermonters

### *1. Government Responsibility*

Most employers feel that the state government does have some responsibility for insuring Vermonters. Primarily, employers believe the government's role to be one of creating an environment where there are affordable options for employers to chose from.

First and foremost in the minds of employers, the government is responsible for encouraging competition in the marketplace. Employers suggested many different ways government could *"level the playing field"* in the insurance market. These suggestions ranged from deregulating the insurance market, assisting employers in pooling together and offering assistance to employers so they can offer health insurance to their employees.

> *"The government should create an atmosphere for competition and be sure there's choices." Medium Employer, Offering Health Insurance, Bennington*

> *"To make a user friendly environment for insurance companies to do business and to meet the needs of our population." Medium Employer, Offering Health Insurance, Burlington*

> *"Make an environment advantageous for insurance companies to stay here." Medium Employer, Offering Health Insurance, Newport*

> *"Open it up so it is easier for insurance companies to come in here and offer [insurance]." Large Employer, Offering Health Insurance, Burlington*

> *"The government's responsibility is to create a marketplace for employers to shop for insurance and get healthcare." Large Employer, Offering Health Insurance, Brattleboro*

> *"I don't want the government to get involved in providing the service; I want them to help me provide the service through a private company." Medium Employer, Offering Health Insurance, Bennington*

Others felt that the government's responsibility should be a strictly ombudsman role, ensuring that health insurance companies are operating fairly. Despite calls for deregulation, some employers would like to see state government regulate the cost of health insurance plans, either by limiting the amount that insurers can charge or ensuring that all groups are charged the same for the same policy, regardless of size.

> *"I think their role should be to make sure that the companies doing business in the State of Vermont are meeting the requirements that are put out, so we have confidence in the companies that we are buying from." Large Employer, Offering Health Insurance, Rutland*

> *"They need to make sure that the insurance companies are paying what they are supposed to." Medium Employer, Offering Health Insurance, Bennington*

> *"[The responsibility of government is] to keep the insurance companies in check. Reasonable rates." Not Offering Health Insurance, Rutland*

A few feel that government should not have any role in the provision of health insurance for Vermonters. A few others would like to see the provision of health insurance be solely the

responsibility of the government – paid for through taxes on substances that cause health problems, such as cigarettes and alcohol.

> *"Ideally, 100 percent government responsibility, but I am scared to say that." "Keep the government out of it as much as we can because they will screw it up." Medium Employer, Offering Health Insurance, Burlington*

Most employers agreed that the state should be responsible for insuring those who can not afford their own health insurance and those unable to work.

> *"I would say for the folks who are not employed, it should be 100 percent government. And if folks are working, it should be their burden." Medium Employer, Offering Health Insurance, Burlington*

> *"We always have people who fall through the cracks that the government has to help with." Small Employer, Offering Health Insurance, Rutland*

### a) Meaning of Government-Funded Insurance Program

Many employers initially had a negative reaction when asked what the term *"government-funded insurance program"* meant to them. Some of the initial associations were: *"bureaucracy," "more taxes," "waste," "Big Brother," "poor care," "under-funded," "monopoly," "socialized medicine"* and *"restrictive."*

Inevitably, the groups brought up Medicare, Medicaid, VHAP or Dr. Dynasaur as examples of government-funded insurance programs. While most lauded Dr. Dynasaur and other Vermont-run health insurance programs, many also expressed wariness about a health insurance or health care program that would be run by *any* government. Many groups also brought up Canada's national health care system. They believe that Canadians experience a lower quality of care and have to wait for time-sensitive treatments. They fear the same would happen in Vermont under a *"government-funded insurance program."*

> *"Isn't that what Canada's got?" "Just looking at what Canada's go. There are no benefits [to a government-funded insurance program]." Not Offering Health Insurance, Bennington*

> *"If you want something that is inefficient, that won't work, that'll cost you more, give it to the government." Medium Businesses, Offering Health Insurance, Newport*

> *"Dr. Dynasaur. Sign me up! It is better coverage than I can afford!" Small Employer, Offering Health Insurance, Rutland*

Participants thought that some of the benefits of such a program would be that it would cover everyone, offer better cost controls, be more affordable, and offer more standardized rates and insurance plans. Some employers mentioned that a benefit would be that they would no longer be responsible for the costs.

*"[A benefit would be] Everyone would be covered." Small Employer, Offering Health Insurance, Rutland*

*"It means better controls on costs." Not Offering Health Insurance, Rutland*

*"The government would pay for it." Not Offering Health Insurance, In-depth Interview*

Participants made two interesting points. First, a number of participants insisted there was no such thing as a *"government-funded"* program, because as they saw it, *"the government is us."* The funding was not coming from the government, these participants emphasized, but from the taxpayers. Secondly, after discussing the idea for a few minutes, many participants indicated that a *"government subsidized"* health insurance program would be acceptable, but a *"government-run"* program would be unacceptable.

*"There is no such thing as government-funded. It is our money." Not Offering Health Insurance, Brattleboro*

*"Everyone has to remember that the government is us. We are the taxpayers, so we are the government." Not Offering Health Insurance, Rutland*

*"Government subsidized, not government run." "That's good." Not Offering Health Insurance, Rutland*

### 2. Employee Responsibility

Initially, when asked what an employee's responsibility in the provision of health insurance was, many employers could not think of any employee responsibility. In fact, some employers did not see where any responsibility would fall on the employee.

*"I don't see the employee having much responsibility to anybody. I mean in car insurance, if your are not responsible, the insurance dumps you. If you're not healthy, they can't dump you. I don't see any responsibility on their part." Large Employer, Offering Health Insurance, Rutland*

*"I don't think you can put any responsibility on the employees." Not Offering Health Insurance, Burlington*

However, after considering the question for a moment, employers determined that an employee's primary responsibility is to maintain their own health and not abuse the healthcare system (thus driving up cost). Employers also thought employees were responsible for being smart healthcare consumers.

*"Take responsibility for their health." Large Employer, Offering Health Insurance, Rutland*

*"Prudent use of resources." Not Offering Health Insurance, Burlington*

*"To be healthy." Small Employer, Offering Health Insurance, Rutland*

*"Two parts that the employee is responsible for: One, responsible use of the benefit and understanding that it is a benefit and, two, trying to stay in shape and not have to use the benefit." Large Employer, Offering Health Insurance, Burlington*

Employers felt employees should be responsible for paying some of the cost of health insurance. They believed this would prompt employees to appreciate the benefit more and be more responsible about their utilization of healthcare.

*"I think if people don't pay anything, they don't really have respect for it." Small Employer, Offering Health Insurance, Burlington*

*"I agree they should share in the costs." Medium Employer, Offering Health Insurance, Newport*

A few participants thought that employees are responsible for making sure that they, and their families, are covered by some type of health insurance plan – either by finding employment with a company that offers it, purchasing their own plan or signing up for a state-sponsored plan.

*"Make them responsible for themselves to a point. We all need to take responsibility for ourselves and our family. If the government is not providing something, we should go out and look for it ourselves." Medium Employer, Offering Health Insurance, Burlington*

*"It is the responsibility of the employee or the individual to make sure that they are covered one way or another." Small Employer, Offering Health Insurance, Rutland*

A few others mentioned that an employees' responsibility is to be politically aware of the state of health insurance in Vermont and make their opinions known to their legislators.

### 3. Employer Responsibility

The underlying assumption in the discussion of employer responsibility in ensuring that Vermonters have health insurance is that employers should provide access to health insurance for employees. Some participants qualified this responsibility by stating that employers *"who can afford"* health insurance should be responsible for providing it.

*"We already have the responsibility. Offering it." Medium Employer, Offering Health Insurance, Newport*

*"Some people, if they are running a business that nets $10,000 a year and they have seven employees, if they offer health insurance, they are out of business. So not everybody is in that position." "If you are talking about the GEs of the world, they can*

*afford to offer it as a benefit, but there are other employers who cannot." Small Employer, Offering Health Insurance, Rutland*

A few employers objected to the idea that it is the employer's responsibility to provide health insurance. This objection was raised most often by medium-size employers and those who are currently not offering health insurance.

*"I think we ought to get out of it. The employer is responsible for giving you wages for work, not taking care of your entire life." Not Offering Health Insurance, Brattleboro*

A few employers believe that the market would determine an employer's responsibility, meaning that if an employer needed to offer health insurance to attract and retain good employees, they would offer it. Some employers felt that if an employer could not afford to offer health insurance to employees, they had a responsibility to help employees find ways to obtain coverage, including private insurance and state-subsidized programs.

Other employer responsibilities mentioned included: providing a safe workplace, on-the-job safety education for employees, helping staff maintain their health, initiating wellness programs in the workplace and educating employees about health issues.

### 4. Division of Responsibility

Most participants agreed that, ultimately, the responsibility for insuring Vermonters is shared among all three entities: government, employers and employees. Thoughts on the proportions of the mix varied from person to person, but generally, most see government as being responsible for providing a hospitable environment for health insurers to do business, employers making health insurance available to employees and employees sharing the cost burden and maintaining their own health.

*"I think, ideally, we'd all like to see it broken up between employee, employer and the government. The three." Not Offering Health Insurance, Brattleboro*

*"Ideally what would happen is that government would make sure the environment existed so there could be a healthy, open, competitive market. Employers would be doing what they are supposed to do -- manage the insurance, research and make insurers be competitive -- and employees would be keeping themselves healthy and getting education about what it means." Large Employer, Offering Health Insurance, Burlington*

Generally, most employers agreed that how much an employer should subsidize health insurance depends on the company's profitability. Some employers believe that the government should assist those employers who cannot afford to subsidize the cost of the premiums for employees. Employers felt the same about the employee's share of the cost burden – that it should depend on ability to pay and that the government should provide a subsidy for those who cannot afford their share.

A few employers believe that responsibility lies solely with one of the three entities discussed.

## E. Participant's Recommendations for Increasing Health Insurance Coverage

Respondents were asked to form groups and discuss recommendations for increasing the number of people who have health insurance coverage. They were asked to develop programs that would be targeted to employers or employees; and to consider the role that four different groups might play in any solutions: individual employers, all Vermont employers as a whole, the government and employees. Employers echo a familiar chorus when asked their recommendations for increasing the number of people who have health insurance in the state of Vermont: *"Reduce the cost."*

> *"There are no incentives. It is purely an economic problem. There's nobody that would refuse health insurance nor anybody that would not want to offer it if it was affordable. The whole problem is a very complex, political one. Reduce the cost." Small Employer, Offering Health Insurance, Bennington*

> *"You better get the costs down. That is the bottom line." "You've got to be able to afford it." Medium Employer, Offering Health Insurance, Burlington*

Participants developed numerous options, many with common themes and inter-related parts. Most groups suggest some type of employer tax incentive to encourage more employers to offer health insurance and to help employers subsidize costs for employees. Some of the participants feel employer tax incentives should only be given to those employers who offer ALL employees health insurance; others feel the amount of incentives should be in proportion to the amount of premiums a company pays.

> *"Offer the incentive to the employer, so that for the employees to take [health insurance], it is free, it does not cost them a thing to have the coverage. But you need to [offer incentives to] the employer for doing that. Some kind of tax break." Large Employer, Offering Health Insurance, Brattleboro*

> *"An incentive to an employer would be a tax break at the end of the year. If you offer insurance to your employees either you could pay a lower tax rate or get some type of rebate for having offered it." Not Offering Health Insurance, Bennington*

Employers recommended funding tax incentives, subsidies or any other government-sponsored solution through the collection of *"sin taxes,"* which they defined as taxes on alcohol, cigarettes, fast food and other items they believe contribute to poor health.

Most also mentioned the need for more choices in the insurance market. While many believe more competition is the solution, most also stated they feel a basic, affordable plan would help more people obtain insurance.

> *"Have more options. A high-deductible, simple plan, major medical, at a reasonable price. I think a lot of people would buy into it, just to have it." Small Employer, Offering Health Insurance, Brattleboro*

In achieving an affordable, basic health plan, employers recommended changing state regulations. Employers think the state should reconsider regulations that require insurers to cover specific treatments in their policies. Employers believe if employers and individuals are allowed to pick and choose the coverage they want and can afford, insurance would be more attainable. Eliminating these regulations would allow insurers to offer more flexible plans and would allow for the creation of that affordable, basic plan. Employers or individuals who wish to have more extensive coverage would be responsible for the additional costs of those options.

> *"We would like to do away with all the state mandates. We feel that is driving the prices up a low as far as the chiropractic mandates and mental health mandates and things like that that keep coming down the pipeline. So now more people are eligible for those and it is becoming a right instead of an insurance and you keep adding items to the bill." Large Employer, Offering Health Insurance, Burlington*

> *"They should de-regulate and let you buy what you think you need instead of forcing you to buy what they think you need or what somebody else might need." Large Employer, Offering Health Insurance, Rutland*

> *"Each employee can come in and say 'I'll take this one. Since I am not going to get pregnant, I am not going to take pregnancy on my insurance so I can get it for less.' Or they can have a higher deductible so they can pick and choose." Medium Employer, Offering Health Insurance, Newport*

Employers also suggested the state allow insurers to charge more for people who fall into high-risk groups, such as smokers, and less for healthy groups that do not utilize health care as much.

> *"There should be some options for healthy groups as opposed to groups that have more sick people." Large Employer, Offering Health Insurance, Rutland*

> *"If they're a smoker they may have to pay more. If they want additional coverage, it is their choice to pay additional to get it. If you have a terminal illness you're going to be charged an additional premium if you did not get in the boat early. People in hazardous situations? Somebody has to pay more for that." Not Offering Health Insurance, Burlington*

> *"The group that jogs at noon instead of eats donuts should get some benefits in their premiums." Medium Employer, Offering Health Insurance, Newport*

Employers also believe by changing the state mandates, it would increase competition in the insurance market and reduce prices, thus making health insurance more affordable and more available in Vermont.

> *"Relax the laws and allow some of those companies back in that were taken out of the state." Small Employer, Offering Health Insurance, Brattleboro*

*"More competition. Competition will make for more affordable premiums." Medium Employer, Offering Health Insurance, Bennington*

*"Change the government rules. That was kind of tied to inviting more insurance companies into the state. The rules they have for regulating the insurance companies have persuaded the other companies to leave the state because the rules are too tight." Small Employer, Offering Health Insurance, Rutland*

Another proposal from many focus groups is to create purchasing pools to help employers obtain affordable health insurance. Some employers would like to see the state assist employers in the creation of these pools; other feel businesses should create the pools on their own. Mainly, purchasing pools were recommended for small businesses, as a way of increasing the bargaining power with insurers.

*"The only way government might be able to help us is they could set up some programs where we could all become part of a network – a pool-type thing." Medium Employer, Offering Health Insurance, Newport*

*"Small businesses should create groups to make a larger pool of workers. So we are not all dealing with 30 / 30 / 30. You get 40 businesses with 30 workers each, that is 1,200 people. Then you negotiate a deal from that perspective or you self insure." Medium Employer, Offering Health Insurance, Bennington*

*"If you went in with 50 you might get a decent rate, but if you went in with 30,000 employees you'd have more bargaining power." Not Offering Health Insurance, Rutland*

A few employers thought that the state should use the entire population of Vermont as a purchasing pool to negotiate attractive insurance rates for all Vermonters. For some, this is similar to the idea of a single-payer health insurance plan. For most, pooling the entire population of Vermont does not mean that all would end up on the same insurance plan, just that the numbers would be used to negotiate better prices.

*"We talked about using the whole state as a group. Maybe getting us all better rates by having the insurance companies just consider the entire population so that we'd have a better rate." Small Employer, Offering Health Insurance, Bennington*

*"The government has to get in and say, 'Now look. We want one, two, three insurance companies to insure all the employees in Vermont.'" Not Offering Health Insurance, Rutland*

One group expanded the pooling idea beyond Vermont. They suggested the state seek to join with other states in the region to form an even larger pool for even greater bargaining power with health insurance companies.

*"We talked about trying to go beyond our borders in Vermont. To make it more regional, New England. As a block of states, approach the insurance companies and negotiate."*

*"If the lottery can do it . . . Vermont is negligible to [insurers] but the tri-states would not be." Small Employers, Offering Health Insurance, Bennington*

Employers feel another way to address issues around the cost of health insurance would be to standardize premium rates so all employers pay the same premiums for the same coverage. (As mentioned earlier, many employers believe smaller groups pay higher insurance premiums than larger groups.) Also, employers feel that if those who do not currently offer health insurance could be guaranteed the cost of the premium for an extended period of time (usually three to five years), they would be more likely to consider adopting a plan because they could appropriately budget for it.

*"If the state could insure some kind of cap on premiums. A sliding cap depending on the size of your business. Like a mortgage, it would rise more or less than x." Small Employer, Offering Health Insurance, Bennington*

Respondents also proposed the state provide catastrophic health insurance for Vermonters who are without insurance. Employers agreed a policy should be developed that would cover part-time and seasonal workers who are not offered health insurance by their employers. Generally, participants did not recommend whose responsibility it should be to develop, sponsor and fund such a policy. However, they recognized these types of employees are in need of access to insurance.

Some participants perceived the need to address the cost of health care as a way to control insurance rates. A few suggested the state regulate health insurance costs, or at least *"monitor"* health care costs.

*"It is controlling costs. If costs can be controlled, the same level of benefit can be offered to a larger number of people at the same costs." Large Employer, Offering Health Insurance, Burlington*

*"As far as government, I think that the government could, through legislation, keep health care under control." Medium Employer, Offering Health Insurance, Burlington*

A few feel it is the state's responsibility to put an end to the cost-shifting. They would like to see government programs paying 100 percent of the cost of care. Employers identified this a one reason their premiums were increasing.

*"Have the government stop using their power to shift cost from the government to the individual taxpayers, meaning have them reimburse at full cost, the actual cost of services that their programs are using." Small Employer, Offering Health Insurance, Rutland*

*"If there is one thing government can do, if they want to cover more people, is to pay all of their cost so that the rest of the people are not burdened [with the cost-shift that makes insurance more expensive]." Not Offering Health Insurance, Burlington*

Some employers believe simply providing employers with information could help. This recommendation has two aspects. First, employers emphasized the need for standardized, easy-to-understand information so it is easier to compare different plans and rates to determine which plans are best for their employees. Employers feel the information should clearly outline what the different plans are that insurance companies offer, what various plans cover and what they do not cover, what out-of-pocket expenses would be and what the deductibles and premium rates would be. Employers feel the information should clearly state what the different plans are that insurance companies offer, including what is and is not covered, out-of-pocket expenses and premium rates.

Second, employers believe if the state were to provide information to employers, employers would be more likely to consider offering health insurance. It was implied that the information provided could clear up misconceptions about price, regulations and options available for affordable health insurance. Employers feel that some of their colleagues would find information about health insurance options helpful.

> *"Educate. Communicate. Let people know what the insurance is, what they are getting, what the policies are." Medium Employer, Offering Health Insurance, Burlington*

> *"We talked about having the Insurance Commissioner get more involved to get information out and to control costs." Small Employer, Offering Health Insurance, Bennington*

Employers also believe providing individuals with information would assist in increasing the number of Vermonters covered by health insurance plans. Employers believe it is their responsibility to encourage healthy lifestyles among their employees, educate them about the costs of health insurance and provide them with information about health issues. Employers feel the state should provide individuals with information about health insurance, specifically about the importance of being covered by insurance and their options if they feel they can not afford health insurance.

Some employers believe insurers should give bonuses or rebates to individuals who maintain good health and do not overuse the healthcare system. They said any cost savings should be awarded to those who are paying the monthly premium – split between employer and employee if they share premium costs.

> *"Employers offer incentives to employees to stay healthy, meaning rebates to people who do not abuse their health insurance." Small Employer, Offering Health Insurance, Rutland*

> *"For people who don't abuse it, they need some incentives or rewards for those who don't abuse, just to try to reduce abuse." Medium Employer, Offering Health Insurance, Newport*

Employers identified other tax incentives the state could provide to individuals that would facilitate more coverage. Allowing individuals a tax-free savings account that could be used to

cover their out-of-pocket medical expenses was one of the ideas. Another is allowing individuals to deduct their out-of-pocket expenses, regardless of the total amount, and without having to itemize their deductions. Finally, employers suggested self-employed individuals be allowed to deduct the full cost of their health insurance.

> *"I think if you want to increase employee participation in coverage you have to give them the ability to feel that if they invest the money, they might get it back if it is not used. The medical savings account." Large Employer, Offering Health Insurance, Burlington*

> *"Right now, unless you do itemized deductions on your taxes you do not get tax credit for medical insurance. What we are saying is that the entire amount that the employee has to pay for health can be some kind of deduction, on a sliding scale, depending on their income." Medium Employer, Offering Health Insurance, Newport*

> *"Allow self-employed individuals the same tax treatment as corporations. Allow them to deduct the full cost of health insurance off their taxes." Small Employer, Offering Health Insurance, Rutland*

There were a few other suggestions that a small number of employers thought would help increase health insurance coverage in the state. First, a few employers recommended that health insurance be required. Some feel that the state should require employers to offer health insurance; others feel the state should require individuals to have it. However, most agreed mandatory coverage would not be an acceptable solution to most people. Second, a small number of employers recommended expanding income caps on existing state-run insurance programs such that more Vermonters would be eligible. Several participants, especially those familiar with Dr. Dynasaur, mentioned that that the program should be expanded to cover parents as well as children. Finally, a few participants mentioned they would like to see the state manage a single health insurance plan for all Vermonters.

> *"It must be an employer requirement to offer it." Not Offering Health Insurance, Burlington*

> *"We talked about mandatory coverage for employees to accept it. Like with auto insurance." Small Employer, Offering Health Insurance, Bennington*

> *"Nobody is going to go for that. Not the employer, not the employee." Not Offering Health Insurance, Rutland*

> *"To have more people insured would require a broadening of programs like Doctor Dynasaur and it would have a broader scope. In other words, rather than just children, it would have to include adults." Medium Employer, Offering Health Insurance, Bennington*

## III. RESEARCH FINDINGS FROM FOCUS GROUPS WITH UNINSURED VERMONTERS

### A. Attitudes toward Health Insurance Today

All participants agreed that having health insurance is very important for themselves and for their families to have. Many participants mentioned that not having health insurance made them uneasy; they worried about what might happen if they were ill or injured. Some participants mentioned that they participated in physically demanding jobs, such as landscaping or construction. Others mentioned that they had physically demanding hobbies, such as hockey or baseball. These participants noted that if they were injured during these activities they would be forced to pay the full cost of their health care cost to a hospital or private physician. Other participants noted that even simple tasks, such as climbing ladder or going down tricky steps, made them think about what would happen if they were to fall. The cost that may be incurred by injuries or illness was a concern for these participants.

> *"I think it [health insurance] is very important. I am an active person and I do things where I could hurt myself. I'd like to know that if I do need medical attention, there is someone to share the cost or assume the cost." Uninsured Vermonter, Burlington*

Participants noted that they often do not seek out preventive care, such as yearly physicals, dental care and eye exams. They also expressed a reluctance to search out medical care when health issues arise. Participants said that they would often wait longer than normal to see if a health issue would go away before seeking care.

> *"You also wait more. When I had health insurance, I would go when I needed to. Now, I wait to see if it will go away." Uninsured Vermonter, Middlebury*

The continuity of care is also something participants believe they are lacking without health insurance. Participants stated that when they do seek out care, they very rarely see anyone who has seen them before or is familiar with them. This lack of continuity meant more time explaining their medical history and a perception that quality of care decreased as a result of lack of personal knowledge between themselves and the practitioners.

Self-employed participants are especially concerned about not having health insurance. They realize that if they were to become seriously ill or have an accident, their livelihood and health would be jeopardized.

> *"I depend on my ability to function to make my living. If I hurt myself I'm sunk." Uninsured, Middlebury*

When participants spoke about having health insurance, it was described as a safety net they could rely on in the event of an illness or injury. Participants also stated that were they to have health insurance they would be able to do more preventative care. This would allow them to see a physician regularly and possibly prevent a serious illness or injury. For these participants,

having health insurance would contribute to a sense of security, and allow them to go through their daily lives without fear of high medical costs and failing health.

> *"If I have health insurance, I know I can get what I need when I need it. It's [not having health insurance is] an extra burden that I don't need to worry about." Uninsured Vermonter, Burlington*

Participants acknowledged that, by not having health insurance, they are gambling with their health. Participants described balancing between the hope that they would not need medical care with the uneasy feeling of what would happen if they fell ill or were injured.

> *"Everyday we balance it and, at the same time, we know we are gambling. I absolutely know I'm gambling. I find that unless something is really, really bothering me, I don't go get health care." Uninsured, Middlebury*

### 1. Where the Uninsured Go For Health Care

When participants were asked where they prefer to go when they need medical care, the majority indicated a preference for area clinics that offer free or sliding scale fees. Many in the group believe that the quality of care at the clinics in their area is very high. Participants expressed that they appreciate that healthcare professionals at the clinics do not stereotype them as they believe some private healthcare professionals have in the past. Participants also feel that the doctors and staff at these clinics take a personal interest in their patient's care.

> *"My son came here when he was very sick. The doctor knew right away what was wrong. It was a lifesaver." Uninsured Vermonter, Burlington*

> *"I had a couple of things come up, and they were there. They helped me out instead of showing me the door. They were really nice." Uninsured Vermonter, Burlington*

> *"I was really relieved to know their was an option that I could afford for when I got sick." Uninsured Vermonter, Middlebury*

Most participants agreed that if such clinics did not exist in Vermont, many uninsured people would either go without care or put off their care until they would require emergency treatment. Other participants suggested that, without affordable clinic access, more people would experiment with home remedies, or reuse old prescriptions left over from previous physician visits. Many participants agreed that without affordable health care the uninsured would have a hard time getting care when they needed it.

> *"It think we would find a whole lot of people very, very, ill and transmitting a whole lot of disease because they don't have the money to go to a doctor. We wouldn't go to the doctor unless is was absolutely life threatening." Uninsured Vermonter, Middlebury*

Other participants stated that they prefer to go to a private healthcare provider when they need treatment. These participants like the familiarity of a physician and staff at a single practice. This is especially true for those who have chronic conditions, such as asthma and diabetes.

> *"I like to go to a doctor that has seen me before, who is familiar with me, and who knows my condition." Uninsured Vermonter, Burlington*

A few participants stated that they regularly seek alternative preventative therapies, such as massage, herbals and energy balancing. It was noted that if a condition became serious, they would seek traditional care with a private physician or at a public clinic.

> *"It depends on my symptoms. I choose more alternative methods. A naturopath or homeopath." Uninsured Vermonter, Burlington*

### 2. Preferred Benefits for Ideal and Basic Health Insurance Plans

When participants were asked to come up with a list of services they would like to see included in a health insurance policy, regardless of the cost, the list was long and varied. The majority of the items on the list were preventive items, such as physicals, eye and ear testing, and dental care. Participants noted that these services are important to them, and could prevent them from becoming seriously ill and unduly taxing the healthcare system.

> *"They always say that if you catch something early, then it can be fixed easily. But if you wait, you end up in the hospital." Uninsured Vermonter, Burlington*

Participants also included more critical care items to their lists, such as sick doctor visits, prescription coverage, emergency care, hospital stays, rehabilitation services, home care and nursing home care. These items were added to the list because they are very expensive.

In an ideal world, some participants said they would also like to see items such as naturopath and homeopath visits, massage, acupuncture, midwifery, chiropractic services, mental health services, sun deprivation therapy, exercise programs, and energy work covered by health insurance plans. These services were mentioned as services that they would use in place of traditional preventative services and treatments.

When participants were asked what services they thought should be included in a basic plan, they provided a shorter list. Most participants listed services such as annual physicals, sick doctor visits, prescription coverage, emergency care, hospital stays and maternity care. Participants also mentioned that they considered yearly dental visits and routine dental work as services that should be covered by a basic health insurance plan.

### 3. Perception of Health Insurance Costs

The actual price of a basic health insurance policy for an individual was thought to be anywhere from $300 to $800 per month, depending on the services covered and the amount of the deductible. Many thought that a plan with a $1,000 to $2,500 deductible would cost

approximately $300 in premiums a month. They thought that a more comprehensive plan with no deductible would cost $800 per month in premiums.

When asked how much would be too much for them to pay in premiums monthly, their answers varied. Some participants noted that anything above $100 or $150 per month would be too much, while others said that the amount should be based on their income. Items such as co-pays and deductibles play a significant role in how much participants are willing to pay for their health insurance. They suggested that monthly premium payments should depend on how much an individual had to pay out-of-pocket for services.

## B. Reasons for Not Having Health Insurance Coverage

A majority of participants had health insurance at one point in their lives, primarily through an employer, although some participants have participated in Medicaid or VHAP. Many participants noted that their children are covered by the Dr. Dinosaur program.

Reasons for not having health insurance varied. The majority of participants lost their health insurance coverage because either they or a spouse changed jobs and were no longer offered health insurance as a benefit through an employer. Some participants are working at part-time or seasonal jobs, which do not offer health insurance. Some chose to leave their jobs to take care of family members at home; others are self-employed. None of these participants felt they could afford private health insurance. A few participants chose not to have health insurance, as they prefer a more natural and alternative approach to healthcare.

> *"I changed my job, and my new job doesn't offer health insurance." "Yeah, me too." Uninsured Vermonters, Middlebury*

> *"I'm self-employed for most of the year and then have seasonal work. They don't offer insurance to us and I can't afford to get it on my own." Uninsured Vermonter, Middlebury*

> *"I definitely have alternative therapeutic solutions, and they are not covered by any health insurance policy." Uninsured Vermonter, Burlington*

### *1. Events That Would Prompt Individuals to Acquire Health Insurance*

When participants were asked what could change in their lives that would make them seek out health insurance, the most common answer was getting a big raise or working for a company that offered coverage. It was participants' perceptions that they simply did not have the financial ability to purchase health insurance on their own. Many participants noted that, while they are uneasy about not having health coverage, they simply can not afford to purchase it.

> *"If I got a big raise. If I had that extra $300 a month, I would consider it because I am nervous about not having it." Uninsured Vermonter, Burlington*

Other participants said that if there were more flexibility in insurance plans and cost, they would be more apt to purchase health insurance. These participants want to be able to choose which services go into their plans, tailoring them to their individual needs. Participants feel that if they could choose the services included in their plans they would not feel that they were paying for services that they do not want or would not use. These participants also want to be able to negotiate the cost of plans, as they do when purchasing a car or other large ticket item.

> *"If I had a lot more plans to choose from and the ability to tailor them, instead of package A, B or C. I want to be able to tailor it to my needs, like a salad bar." Uninsured Vermonter, Middlebury*

Another participant suggested that the philosophy of insurance companies would have to change for her to consider obtaining health insurance. This participant was not comfortable with an insurance company acting as a middleman between herself and her provider. One participant suggested that the state mandate health insurance coverage, as with car insurance. It was this participants' view that if she were forced to pay for health insurance she would find a way. Another participant said that she would purchase health insurance if more alternative therapies were covered by health insurance plans.

## C. Barriers to Acquiring Health Insurance

The main barrier the uninsured face is the cost of health insurance plans. The majority of participants are not offered health insurance through their employers and believe they can not afford to buy it privately. Not being covered distresses participants, but at the same time they can not justify the cost of the plans. It is only after all the other monthly bills are paid that participants asses their ability to purchase health insurance.

> *"My husband is self-employed, and it is just so expensive that we just can't afford it." Uninsured Vermonter, Burlington*

> *"I think health insurance to everybody is very, very important. We all need it, but when it comes down to the mortgage, the car insurance, feeding the family and buying medications…It's always the last thing." Uninsured Vermonter, Middlebury*

Another major barrier to acquiring health insurance is the perceived value of the plans versus their cost. Participants feel that if they add up all the money that they would pay for a health insurance plan in premiums, deductibles and co-pays, it would cost more than if they were to pay directly out-of-pocket for services actually used.

> *"It seems important because if I get hurt it will be there but if I don't, then it's like paying for something I don't use." Uninsured Vermonter, Middlebury*

> *"The reality is if you have to pay [for health insurance premiums] every month for the rest of your life, chances are you are going to pay more than if you paid $10 or $20 out-of-pocket when you needed it." Uninsured Vermonter, Middlebury*

There was a higher comfort level with working out payment plans with healthcare providers for services used than paying a large insurance company for services that you may or may not use.

> *"I think it's easier to work out a payment plan with our healthcare provider. You pay someone you know for the services they gave you." Uninsured Vermonter, Middlebury*

A few participants noted that they do not use traditional medical services and, therefore, see no value in having health insurance. These participants prefer a more natural approach to their health and seek services not covered by most health insurance plans.

> *"The healthcare that I seek out is not covered under any health insurance plan. I use more alternative, preventative, more natural health care. If I had health insurance, I would be paying for services that I wouldn't use." Uninsured Vermonter, Middlebury*

## D. Responsibility for Providing Health Insurance

Participants were asked to respond to two statements regarding the state government's role in health insurance. The two statements represented extreme views of state government purview. The first statement suggested that the state government should not have a role in people's personal lives, including health insurance. The second statement suggested that the state should be involved with people's personal lives by protecting them from hardship and helping them with health insurance. The majority of participants identified with the second statement. They felt the state should help those who are financially less fortunate or uninsured in a variety of ways including providing health insurance. The idea of a state-funded health care system was brought up by participants as a possible solution. Expanding the open door clinic with sliding scale fees, and those of the existing VHAP and Dr. Dinosaur for all Vermonters was also mentioned.

> *"I think the government should help out more with people who don't have jobs or are between jobs. I think there is an obligation of the state to help them out." Uninsured Vermonter, Burlington*

There were concerns over the amount of government involvement in people's daily lives with a state-run health care program. Participants used the Canadian and U.K. health care models as examples of how government-run health programs have not worked as well as private care systems. Participants felt too much government involvement will make the system more confusing and harder to use than what we have now.

> *"Government has a tendency to create more problems than there were when they started." Uninsured Vermonter, Middlebury*

Some participants believed there is a place for government involvement, particularly, in the area of regulation of profits of insurance companies and the cost of health care. Regulation of prescription drug costs was also an area where participants thought the government can make a positive contribution.

*"I think there needs to be some intervention for the government as far as regulation on profits. How is it that the pharmaceutical companies can charge outrageous prices for us but in Mexico you can go and buy the same prescription for one-tenth what it costs us here?" Uninsured Vermonter, Middlebury*

When participants were asked who should be responsible for providing health insurance to Vermonters, the most common answer was a split between the employer and state government. In this situation the employer would offer plans to its employees and the state would subsidize the cost to the employers. Employers and employees would share the premiums of these subsidized plans. Participants thought such a sharing of cost would allow smaller employers to offer health insurance to its employees for a reasonable rate. This idea was not popular with self-employed participants.

*"The state government would step in to provide money to employers who cannot afford to offer health insurance. Then the insurance would be affordable for the employer and the employee." Uninsured Vermonter, Burlington*

*"That would be tough for me because I am an independent contractor I am both the employer and employee." Uninsured Vermonter, Middlebury*

Participants also questioned how the state would provide subsidies to employers for insurance premiums. The concern was the state might end up giving subsidies to employers who do not need them. Participants thought any subsidy should be given to smaller companies who either could not offer coverage or were having financial difficulty providing coverage.

Other participants thought responsibility for health insurance should be between individual employers and employees without any involvement from state government. It would be the employer's responsibility to offer affordable health insurance plans to their employees and employees would share in the cost of the plans.

With regard to children, unemployed adults, those between jobs, or the financially disadvantaged, participants believe the state should bear the responsibility to offer them health insurance until they can afford to get it on their own.

*"I believe the state should help lower wage people." Uninsured Vermonter, Burlington*

*"The state government [responsibility] is big when I think of kids." Uninsured Vermonter, Middlebury*

When participants were asked how appealing the idea of participating in a state-sponsored health insurance program is, the answers were mixed. Those interested in the idea were drawn to it because they feel everyone should have affordable coverage no matter what. They also feel that they should have equal treatment as far as seeing healthcare providers and getting the same level of care.

*"I think the best idea is for everyone to be covered under a government plan. That way everyone would be covered and everyone can get care." Uninsured Vermonter, Burlington*

Those not interested in a state-sponsored health insurance program feel there are benefits, but thought the disadvantages outweigh them. These people are concerned with the possibility of strict regulation, a lack of freedom in choosing a provider or method of care, long periods to receive care, and a decline in the quality of care. They are also concerned that health insurance will be one more thing in their daily lives that the government will control.

*"People in Canada need to wait for treatment and there are all these policies that they have to follow. I don't want that." Uninsured Vermonter, Middlebury*

*"I would be afraid of government control." Uninsured Vermonter, Burlington*

When participants were thinking about a state sponsored health insurance program, some participants are uncomfortable with the state giving money to a health insurance company. Participants feel health insurance companies will only profit from the deal and will not offer a variety of plans to suit the needs of all Vermonters. These participants suggested the state give subsidies directly to the people of Vermont and allow them to purchase insurance or alternative care on their own. The feeling behind this suggestion is the state of Vermont will allow people to afford health care in whatever manner they choose to get it. If people want to purchase health insurance or directly pay their providers, including alternative care providers, they will have the freedom to do so.

*"It's a bad idea to use our tax dollars to give to a company who makes billions. They are just going to put it in their pockets and give the CEO a big raise." Uninsured Vermonter, Middlebury*

*"Then we could make a choice as to what we could buy and what our needs are." Uninsured Vermonter, Middlebury*

When asked how many participants would sign up for a state funded health insurance program nearly all of them said that they would simply for the fact that they would have coverage.

*"I need the coverage. It's a security. I feel very insecure not having any coverage because anything could happen." Uninsured Vermonter, Burlington*

Many participants liked the idea of expanding existing VHAP programs to include higher income brackets. Participants were also open to the idea of the state offering insurance to those who were severely ill. They believed such a state-funded program would have to be clearly defined so Vermonters would know what their tax money was being used for. Participants liked the idea of the program being funded with a tobacco tax, although it was noted a tobacco tax was an unreliable source of income. The idea that the program would be funded with an assessment or surcharge on all insured persons' plans was not popular with participants. Participants explained that if part of an insurance premium would go towards funding an insurance program

for the uninsured it would be difficult to sort out how much each insured person should be taxed. Participants noted that people have a wide variety of health insurance plans ranging from basic catastrophic to full coverage. These plans also vary in price and it would be unfair for the person with the catastrophic plan to be taxed as much as the person who has the full coverage plan.

> *"If we were all contributing a percentage of the same plan it wouldn't be bad but right now we all have such different coverage and payments, it wouldn't be fair." Uninsured Vermonter, Burlington*

Tax breaks for employers who offer health insurance was an idea that was well received. Participants believe tax breaks would benefit companies because health insurance is important for attracting and retaining valuable employees. Employees want coverage for themselves and their families. Participants believe if more people have health insurance coverage, there will be more competition between providers in the state, the cost of health insurance will go down, and the variety in plans will increase.

> *"It's a win-win situation they [employers] are getting a tax break and they can provide service to their employees." Uninsured Vermonter, Burlington*

> *"More employees will bring the cost down and they would have to add more plans. It would spur competition." Uninsured Vermonter, Middlebury*

Although many believe employer-tax incentives is a good idea, participants are also concerned about this plan as well. Participants noted that even if employers offer health insurance, employees still may not be able to afford their share, especially if they are part-time or seasonal workers. Participants suggested the employee's share of the premium be based on a percentage of the employee's income. Also, participants want companies to offer health insurance to all employees, even if the employees are part-time, or seasonal in order to qualify for the tax incentives.

Again, participants are concerned that some employers may not need the tax incentives. Participants believe smaller companies, or companies that do not make a large profit, should be eligible for the tax incentives but large companies with large profits should not be eligible for such tax incentives.

> *"Look at IBM! (snicker) You want to give them a tax cut?! They have huge profits, they don't need a tax cut to offer their employees health insurance." Uninsured Vermonter, Middlebury*

### 1. Attitudes toward Medicaid

In general, participants' initial reactions to the word "Medicaid" were negative. Words and phrases such as: poor, welfare, income based, stereotyped, and people with disabilities came out. Some of the participants had been on Medicaid at some point and have mixed reactions. On the negative side, people told stories of not getting the care they needed and being turned away by health care providers.

*"I have a friend who is a receptionist in a doctor's office. She said that the doctors told her to schedule the Medicaid people way out and get the people who had insurance or were paying cash in first." Uninsured Vermonter, Middlebury*

On the positive side, some participants noted that without having Medicaid they or their children would not have gotten any care at all. Participants also see Medicaid as a safety net for those who are unable to work or are unable to get care.

*"It was a saving grace for me, without it I wouldn't have had care for my baby." Uninsured Vermonter, Burlington*

## E. Recommendations for Increasing Health Insurance Coverage

Participants had a wide variety of recommendations for increasing health insurance coverage to more Vermonters. Many of the recommendations include shared responsibility between the state, employers and insurance companies.

Many participants recommend expanding the eligibility of existing state-funded health insurance programs. Participants believe this will allow more people to participate in health insurance programs. Participants also recommend the state consider each case individually, taking into account possible mortgage and car payments when looking at income caps.

*"VHAP is there, why don't we make it more accessible to people by relaxing the income requirements?" Uninsured Vermonter, Middlebury*

*"I'd like them to have more of an individual consideration, take into account that we pay mortgages and car payments." Uninsured Vermonter, Burlington*

Another popular recommendation is for the state to educate people about the programs that are available currently. There is a perception among participants that more people will take advantage of state-funded programs if they know what programs are available and what the eligibility guidelines are.

*"There has to be education that lets people know what exists, what the availability is." Uninsured Vermonter, Middlebury*

A few participants want to have the state government and the federal government team up to reduce the cost of health insurance through regulation of profits that are made by health insurance companies. These participants believe health insurance companies are making too much profit and not providing enough services to the people they insure.

*"The federal government needs to get involved with the state to regulate the health insurance companies and their profits." Uninsured Vermonter, Middlebury*

Participants also have recommendations for the insurance companies. Some participants want insurance companies to offer an incentive program for people that do not use their health insurance frequently. This program would be modeled after auto insurance policies, where, if you go for a certain amount of time without having an accident, you get a discount on your auto insurance bill. Also, with auto insurance, there is a discount for a multiple number of cars covered. With this health insurance program, you would get a discounted rate for covering your family.

> *"Like with your car insurance, if you go for a certain amount of time and you haven't had an accident you would get a discount." Uninsured Vermonter, Burlington*

Participants also want insurance companies to offer more flexible plans that allow people to choose what services they want have included in their plans. This will allow people to customize their care to meet their individual needs.

> *"That way I could choose what I need and want." Uninsured Vermonter, Burlington*

Recommendations to employers include offering part-time and seasonal employees health insurance. It was suggested employers would base the employees' share of the premium cost on their income.

> *"Employers should offer health insurance, even if it's just basic insurance, to part-time employees." "Employees would pay into the plan based on their salary." Uninsured Vermonter, Burlington*

One participant suggested the state should offer and fund a health insurance program for all Vermonters. The participant believes this will allow all Vermonters to be covered under the same program with the same rights and services available. Another participant suggested the state make it mandatory for citizens of Vermont to have health insurance. In this recommendation, the state would also be responsible for making sure health insurance is affordable for all Vermonters. One other participant recommends the insurance company be taken out of the scenario all together. In this recommendation, Vermonters will directly pay their healthcare provider for services.

> *"In an ideal system there would be no middle agent of the health insurance company. You would pay directly to your doctor." Uninsured Vermonter, Middlebury*

## IV. CONCLUSION

Employers believe that health insurance is one of the most important and most valuable employee benefits. Even employers who do not offer health insurance recognize insurance as a valuable tool for recruiting and retaining employees. However, employers also stated that employees often find larger paychecks and paid time off to be more valuable than health insurance. Some employers stated that employees refuse insurance because they do not want, or cannot afford, to pay their premium splits. They also indicated that as long as employees will work without health insurance as a benefit, there will be employers who will not offer it.

Vermont employers are nervous about health insurance, a subject that touches an emotional chord with nearly all employers, from self-employed individuals to the state's largest businesses. Whether or not they are currently offering health insurance, employers expressed frustration and anxiety over the issue. They see the Vermont insurance market as volatile. As a result of changes in the market -- primarily a number of health insurers leaving the state during the past few years and the rising cost of insurance premiums -- employers feel out of control with respect to planning for health care expenditures. This perceived volatility causes those who do not offer insurance to be afraid to commit to offering a plan, and those who do offer plans (especially small employers) to be concerned that they will not be able to continue to offer benefits at their current level.

While most employers who currently offer insurance believe that they will continue to do so, more and more are shifting the cost of health insurance to the employee by increasing the employee contribution to the premium or raising deductibles and co-pays. For employees, these changes mean higher out-of-pocket health care costs, one of the primary reasons employees refuse to accept employer-sponsored health insurance.

While cost was cited as the primary barrier to health insurance access, there were non-cost-related barriers mentioned as well. Some do not see the value in paying health insurance premiums because what they would pay on an as-needed basis is less than their potential premium and co-pay costs. Employers complained that employees do not understand the full cost of offering health insurance, or believe they are entitled to it, and, therefore, do not value insurance as highly as employers think they should. For some, researching health insurance plans and finding reliable, unbiased information has proven to be an overwhelming task.

Throughout all of the focus groups, respondents repeatedly told us that health insurance needs to be financially accessible in order for more Vermonters to be covered. Both individuals and employers lament the lack of a basic, affordable health insurance plan, one that would cover preventive care, sick doctor visits and catastrophic medical needs with a *"reasonable"* deductible and co-pay.

Employers will not adopt a plan that their employees would not view as a benefit. Many stated that high deductible plans undermine the benefit of health insurance because employees have to pay too much money before they are covered. Additionally, employers and individuals alike said they would feel more confident about enrolling in a health insurance plan if they could anticipate the future cost or at least knew the maximum percentage increase for which to budget. Some employers who do not currently offer health insurance said they would cover at least some of their employees if they could get a plan that did not require signing up 75 percent of their eligible employees[1].

Many employers believe that health insurance needs to be made available to Vermonters who work part-time, seasonally or as contract employees. Employers are concerned that they would not be able to collect the employee portion of the premiums from such employees, or that those employees do not earn enough to afford their portions of the premiums. If there were a program

[1] *Some employers may not fully understand this restriction, as many believe that it is an insurance company rule. Others are unclear on how* "eligible" *is defined.*

that would assist employers in administering and collecting payment for health insurance from these employees, they would be more inclined to offer it.

Many employers and individuals are convinced that more competition would reduce the cost of health insurance. While they conceded that other influences, such as rising healthcare cost and overuse of the system, play a role in increasing insurance premiums, many are convinced that the main reason is decreased competition among insurers. Employers also believe that state mandates regarding coverage for specific treatments and community rating have spurred lack of competition by prompting insurers to leave the state. Employers stated that there will be *"enough"* insurers in the state when they can purchase a basic policy at a reasonable premium rate.

Employers also envisioned the development of purchasing pools as a possible method of increasing the number of insured in Vermont, as pools would enable them to bargain more effectively with insurance companies for lower premium rates. Employers suggested pooling either by industry or by size of business. While some would like to see businesses do this on their own, many would like to see the state government help such groups organize themselves.

With regard to the role that government should play in providing Vermonters with health insurance, employers clearly believe that the government should start by creating a hospitable regulatory environment in which insurers can conduct business. Government should then take measures to ensure that the insurance market remains healthy and that insurers are legitimate businesses. Employers also believe that government should provide insurance for those who do not have access to it. Uninsured Vermonters see an expanded role for the government, primarily in ensuring that all Vermonters have health insurance. Despite disagreement about the extent of government involvement, most in all of the focus groups agree that government should assist people in obtaining health insurance, but not be involved in the administration of healthcare.

Employers devised numerous recommendations for increasing the incidence of health insurance coverage in Vermont. The most popular recommendation was setting up employer tax incentives for offering employees health insurance. Another popular suggestion was to subsidize premium costs for both employers and employees. The uninsured participants supported expansion of state programs so that more Vermonters could join.

# Appendix I
# Focus Group Discussion and In-depth Interview Guides

**Businesses Offering Coverage**
**Focus Group Discussion Guide**
**(Draft 3, 1/5/00)**

***Focus Group Objective:*** *What factors influence employers' decisions to offer employees health insurance, and what factors will determine whether they will continue to offer it. Discuss ways in which health insurance coverage could be expanded to those who are currently uninsured.*

## 1. Introductions (10 minutes)

### *Moderator Introduction*

Welcome, my name is _____ and I'd like to thank you for taking the time to share your opinions with me tonight. We have invited you here tonight to talk about health care coverage in Vermont and the role of employers in providing health care coverage. Before we get started, I'd like to talk about our focus group tonight:

? Has anyone ever participated in a focus group before?

? I'd like you all to feel comfortable. If you need to get up, get a drink, or use the restroom, please feel free to do so.

? *(The moderator will point out any recording devices and talk about why we are recording.)*

? Everyone's participation is valuable; we need to hear everyone's honest opinions. Feel free to say whatever you think.

> I work for an *independent* research company; my job will not be influenced by anything that is said here tonight.
>
> Everyone's opinion is valuable and it is important that I hear from everyone.
>
> I may call on you or ask for your views specifically.
>
> I may interrupt you to move the conversation on.
>
> I am not trying to single anyone out, or cut anyone off; I am just doing my job.

? There are a couple of "rules" I'd like us to follow tonight: speak one at a time, and speak up; no side conversations; and the best answers are what is TRUE for YOU.

> I want everyone to "agree to disagree." Tonight we will welcome all different points of view. There are no right or wrong answers.
>
> I just ask that we not have more than one person away from the table at a time.

### *General Introduction*

Let's start the evening by going around the table and introducing ourselves. I'd like each of you to tell us 4 things: your first name, your current occupation, where you live and what you like to do in your spare time. *(Moderator goes last.)* Thanks for coming; lets get started with our discussion for tonight.

## 2. Company Benefits (5 minutes)

Brainstorming Exercise

First, could you tell me about the different benefits that a company might offer its employees?

Written Exercise

I would like you to write down on the pads of paper in front of you what you feel are the three most important benefits:

A) From the perspective of your employees. *(i.e., Which do you feel they value most?)*

B) From the perspective of your company. *(i.e., Which are most advantageous for your company to offer?)*

***(Collect responses; brief discussion, if time allows)***

? What company benefits do employees consider vital?
? Which benefits do you feel are *not* essential for companies to offer their employees?

## 3. Employee Health Coverage Details (20 minutes)

Let's talk for a few minutes about health care coverage at your current company. I'd like to start off with a different kind of exercise.

Creative Exercise –Facial Drawings

(*The moderator will hand out sheets of paper with a blank face on them. Respondents will be instructed to draw the facial expression that best represents their company's attitude toward health coverage for their employees. Underneath the face, respondents will briefly describe the expression and their company's policy toward health coverage.)*

***(Discuss drawings.)***

? What kind of facial expression did you draw? Please explain.
? How would you describe your company's attitude toward health coverage?

***(Ask each respondent.)***

? What types of health benefits do you currently offer employees?

? How many plans do you offer? [If more than one, do the plans vary by geography?]

? To what percentage of your employees do you offer health coverage?

? How are the costs of coverage shared between employer and employee (ratio)?

? What percentage of your employees accepts the coverage?

Describe the types of employees who accept it
*Age, family status (married, with children, single, etc.), salary*

Which elements of the plans do you think effect whether or not an employee accepts coverage? *(Probe for: cost, benefit comprehensiveness, spousal coverage, etc.)*

? What about the other employees, are they covered elsewhere or uninsured? Please explain.

For those who decline coverage

For those who are not offered coverage

? For the employees not offered coverage, what are the reasons you do not offer them coverage?

## 4. Factors Influencing in Employers' Decision to Provide Health Insurance (20 minutes)

Brainstorming Exercise

? What would you say are the main reasons your company decided to offer health benefits to employees? *(Moderator will write reasons on flip chart.)*

? Of all of these reasons, which is the most important reason why employers offer health insurance to employees? *(Moderator will mark which reason is most important.)*

? How does your company benefit from offering employee health coverage?

? How do you think employees benefit from having coverage?

? Please describe a situation or an example at your company that highlights the benefits of offering health insurance coverage.

? What are the main drawbacks to offering coverage from the company's perspective?

? Please describe a situation or example at your company that highlights the disadvantages of providing coverage.

? How does your company respond to premium increases? Please explain.
*(Listen for reducing/discontinuing benefits; increasing copayments/employee contributions; reducing company expenses/profits; raising prices, etc.)*

? Under what conditions would your company have to seriously reassess the health coverage it offers? Please explain.

? How would you consider changing the coverage offered?
*(Probe if necessary: the employer/employee contribution ratio; seeking out cheaper plans; other benefit reductions, etc.)*

? In what situations would you not offer coverage?
*(Probe as to what % of a premium increase would be unacceptable.)*

? What do you see as the biggest barriers to offering all employees health insurance for companies in Vermont? *(Probe for administrative costs, administrative time, cost to company, lack of employee interest, regulations, etc.)*

## 5. Providing Health Coverage in Vermont (30 minutes)

*The aim of this section is to explore ways to increase health coverage among Vermont employees.*

? Describe the responsibility for health coverage in Vermont that each of the following parties carries.

Employers
Government
Employees

? How has the burden of providing health coverage to employees in Vermont shifted over the years?

? Who do you think should be responsible for health coverage?

How should it be shared? Please explain.

### *Ideas to Increase Coverage*

<u>Creative Exercise - Increasing Health Coverage among Uninsured Vermont Employees</u>
*Now, I would like to put you into two small groups and have one group member jot down your key points. Let's imagine that your group has been hired by the state of Vermont to come up with ideas and practical ways to increase health coverage of Vermont employees. I would like you to spend a few minutes discussing different options and possible solutions.*

### *Guidance*

? During your discussions, consider the roles and responsibilities of:

Vermont employees
Individual Vermont employers
Vermont employers as a group

The state

? Include examples that would:

Offer Vermont employers incentives to extend coverage to all employees
Encourage Vermont employees to take advantage of employer-sponsored coverage

***(Discuss each group's responses.)***

? What sort of ideas and recommendations did your team come up with?

? Which one idea/recommendations do you feel will be most readily embraced:

by Vermont employers?
by Vermont employees?

***(Probe as necessary.)***

? How appealing is the idea of participating in a government-funded insurance program?

What would be the advantages of participating?

What would be the disadvantages of participating?

Explore what "government-funded insurance program" means to participants. *(i.e., is it similar to welfare, done through tax incentives, how would it differ from workman's compensation)*

? How do you feel about state funds being used to help make coverage more affordable to lower-wage employees in Vermont? Please explain.

## 6. Summary (5 minutes)

*In this section, the moderator will recap the items discussed and things learned in the discussion. Respondents will be asked to recap their main points.*

? Are there any additional relevant comments that you would like to make at this point?

? Is there anything that we missed? Please explain.

There is one last thing I'd like to do tonight before you collect your stipends and go home. I'd like to go around the table and have each of you tell me two things:

? What would be your final recommendation to increase coverage of Vermont employees, and should the government play a role, if so, how?

***(Thanks, provide instructions on stipends, and close.)***

**Businesses NOT Offering Coverage**
**Focus Group Discussion Guide**
**(Draft 3, 1/5/00)**

***Focus Group Objective:*** *What factors influence employers' decisions not to offer employees health insurance. Discuss ways in which health insurance coverage could be expanded to those who are currently uninsured.*

## 1. Introductions (10 minutes)

### *Moderator Introduction*

Welcome, my name is _____ and I'd like to thank you for taking the time to share your opinions with me tonight. We have invited you here tonight to talk about health care coverage in Vermont and the role of employers in providing health care coverage. Before we get started, I'd like to talk about our focus group tonight:

? Has anyone ever participated in a focus group before?

? I'd like you all to feel comfortable. If you need to get up, get a drink, or use the restroom, please feel free to do so.

? *(The moderator will point out any recording devices and talk about why we are recording.)*

? Everyone's participation is valuable; we need to hear everyone's honest opinions. Feel free to say whatever you think.

> I work for an *independent* research company; my job will not be influenced by anything that is said here tonight.
>
> Everyone's opinion is valuable and it is important that I hear from everyone.
>
> I may call on you or ask for your views specifically.
>
> I may interrupt you to move the conversation on.
>
> I am not trying to single anyone out, or cut anyone off; I am just doing my job.

? There are a couple of "rules" I'd like us to follow tonight: speak one at a time, and speak up; no side conversations; and the best answers are what is TRUE for YOU.

> I want everyone to "agree to disagree." Tonight we will welcome all different points of view. There are no right or wrong answers.
>
> I just ask that we not have more than one person away from the table at a time.

### *General Introduction*

Let's start the evening by going around the table and introducing ourselves. I'd like each of you to tell us 4 things: your first name, your current occupation, where you live and what you like to do in your spare time. *(Moderator goes last.)* Thanks for coming; lets get started with our discussion for tonight.

## 2. Company Benefits (15 minutes)

Brainstorming Exercise

First, could you tell me about the different benefits that a company might offer its employees?

Written Exercise

I would like you to write down on the pads of paper in front of you what you feel are the three most important benefits:

A) From the perspective of your employees. *(i.e., Which do you feel they value most?)*

B) From the perspective of your company. *(i.e., Which are most advantageous for your company to offer?)*

***(Collect responses; brief discussion)***

? What company benefits do employees consider vital?
? Which benefits do you feel are *not* essential for companies to offer their employees?

Let's talk for a minute about health insurance coverage.

? Has your company ever offered health benefits?

[If have offered] What led the company to no longer offer health insurance benefits?

[If have offered] How did employees react to the fact that the company was no longer offering coverage? Please explain.

[If never offered] Why doesn't your company offer insurance to employees?

? Are your employees covered elsewhere or uninsured? Please explain.

## 3. Factors Influencing in Employers' Decision Not to Provide Health Insurance (20 minutes)

Brainstorming Exercise

? What would you say are the main reasons your company decided NOT to offer health benefits to employees? *(Moderator will write reasons on flip chart.)*

? Of all of these reasons, which is the most important reason why employers DO NOT offer health insurance to employees? *(Moderator will mark which reason is most important.)*

? What do you see as the main:

advantages to not offering coverage?

drawbacks to not offering coverage?

? What do you see as the key benefits for a company providing health coverage?

How do you think the employees benefit from having coverage?

? Discuss the role of each of the following in the decision not to offer health insurance coverage:

The cost of the plan per employee (premium rates and employer/employee contribution ratio)

Administrative time/paperwork

Integration of health insurance with business insurance

Pre-existing conditions limitations

Are there any other factors critical to your decision we should discuss?

***Coverage Barriers and Triggers***

? Which factors pose the biggest barriers to offering coverage in Vermont?

What do you see as the reasons for this?

? Under what conditions would your company consider offering health coverage? Please explain. ***(Probe as necessary.)***

## 4. Providing Health Coverage in Vermont (30 Minutes)

*The aim of this section is to explore ways to increase health coverage among Vermont employees.*

? Describe the responsibility for health coverage in Vermont that each of the following parties carries.

Employers
Government
Employees

? How has the burden of providing health coverage to employees in Vermont shifted over the years?

? Who do you think should be responsible for health coverage?

How should it be shared? Please explain.

***Ideas to Increase Coverage***

Creative Exercise - Increasing Health Coverage among Uninsured Vermont Employees
*Now, I would like to put you into two small groups and have one group member jot down your key points. Let's imagine that your group has been hired by the state of Vermont to come up with ideas and practical ways to increase health coverage of Vermont employees. I would like you to spend a few minutes discussing different options and possible solutions.*

***Guidance***

? During your discussions, consider the roles and responsibilities of:

Vermont employees
Individual Vermont employers
Vermont employers as a group
The state

? Include examples that would:

Offer Vermont employers incentives to extend coverage to all employees
Encourage Vermont employees to take advantage of employer-sponsored coverage

***(Discuss each group's responses.)***

? What sort of ideas and recommendations did your team come up with?

? Which one idea/recommendations do you feel will be most readily embraced:

by Vermont employers?
by Vermont employees?

***(Probe as necessary.)***

? How appealing is the idea of participating in a government-funded insurance program?

What would be the advantages of participating?

What would be the disadvantages of participating?

Explore what "government-funded insurance program" means to participants. *(i.e., is it similar to welfare, done through tax incentives, how would it differ from workman's compensation)*

? How do you feel about state funds being used to help make coverage more affordable to lower-wage employees in Vermont? Please explain.

## 5. Summary (5 minutes)

*In this section, the moderator will recap the items discussed and things learned in the discussion. Respondents will be asked to recap their main points.*

? Are there any additional relevant comments that you would like to make at this point?

? Is there anything that we missed? Please explain.

There is one last thing I'd like to do tonight before you collect your stipends and go home. I'd like to go around the table and have each of you tell me two things:

? What would be your final recommendation to increase coverage of Vermont employees, and should the government play a role, if so, how?

***(Thanks, provide instructions on stipends, and close.)***

# Appendix II
# Facial Expressions Regarding Health Insurance

**Available upon request**

# Appendix E:
# Reserve Requirements for Health Care Benefits Plans

**Available upon request**

# Appendix F:
# Analysis of the Costs and Impact of Universal Health Care Coverage Under a Single Payer Model for the State of Vermont

# Analysis of the Costs and Impact of Universal Health Care Coverage Under a Single Payer Model for the State of Vermont

Prepared for:
**The Vermont HRSA State Planning Grant,**
**Office of Vermont Health Access**

***August 28, 2001***

**Final Report**

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U.S. Department of Health and Human Services.

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## EXECUTIVE SUMMARY

The purpose of this analysis was to explore the expected costs and impacts of a single-payer program in which all state residents are covered under a single public program funded primarily with an employer payroll tax.

Our analysis indicates that the single payer model would cover all Vermont residents, including the estimated 51,390 uninsured persons in the state, while actually reducing total health spending in Vermont by about $118.1 million in 2001 (i.e., five percent).[1] These savings are attributed primarily to the lower cost of administering coverage through a single government program with uniform coverage and payment rules.

The single-payer program would greatly redistribute health care costs across families in various income groups by shifting from today's premium based system to a tax based system where individual payments for health coverage increase in proportion to income. For example, families with incomes below $75,000 would on average find that their new tax payments under the program are more than offset by the elimination of premium payments and reductions in out-of-pocket spending under the plan. However, under the tax-based system, families with incomes of $75,000 or more will, on average, see a net increase in spending for health care.

In this report, we present our analyses of the financial impact of a single-payer program on various payers for health care including state, local, and federal governments. We also estimate the financial impact of the proposal on employers by industry and firm size. In addition, we estimate the impact of the plan on household health spending by age, income level, and other characteristics.

### The Single-Payer Proposal

The single-payer model is one where all individuals in the state are covered under a single uniform health plan that is administered and funded by the state. The new single-payer system would replace all current public-sector insurance systems including: Medicare, Medicaid, CHAMPUS and the Federal Employees Health Benefits Plan (FEHBP). It would also replace private health insurance plans in the state. The program would be financed with current government health care funding for discontinued programs and new taxes on employer payroll.

The single-payer benefits package would be modeled on the benefits typically provided under employer health plans. The program would cover medically necessary inpatient hospital care, physician services (including preventive care), hospital outpatient care, prescription drugs, lab tests, and mental health services (including substance abuse and tobacco cessation). Chiropractic services would be covered when referred by a physician. The program would cover preventive dental care and vision exams, but it would not cover orthodontia, private rooms, or eyeglasses.

[1] "Counting What Counts: Health Insurance Coverage in Vermont, First Findings From the Vermont Family Health Insurance Survey" Vermont Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA), July 2001.

To discourage over-use of services, there would be a $10.00 copayment for ambulatory care services. There would be no deductible. Also, the program would use a primary care provider referral (i.e., gatekeeper) model where patients face increased copayments for visits to specialists without referral. Benefits that are currently provided to Medicaid eligible persons that are not covered under the single-payer model would be continued for low-income persons who qualify for Medicaid under current eligibility rules.

## Health Spending Under The Single-Payer Program

We estimate that total health spending for Vermont residents under the current system will be $2.2 billion in 2001. This includes spending for all health care services including benefits payments and insurer administration. We estimate that the single-payer program would achieve universal coverage while actually reducing total health spending by about $118.1 million in 2001 (***Table ES-1***). The primary reason for this savings reduction is that the single-payer model substantially reduces the cost of administering health insurance coverage, resulting in savings that can be used to pay for the care that would be provided to persons who are currently going without coverage.

**Table ES-1**
**Changes in Health Spending in Vermont under a Single-Payer Program in 2001**
**(in millions) [a/]**

| | | Changes in Spending |
|---|---|---|
| **Changes in Health Services Utilization** | | |
| Increase in Utilization Due to Expanded Coverage | | $62.9 |
| Utilization Increase for Previously Uninsured | $23.1 | |
| Expanded Coverage for Those Already Insured | $39.8 | |
| **Change in Administrative Costs** | | |
| Net Change in Administrative Costs | | ($153.6) |
| Insurer Administration (Includes Administration for Newly Insured) | ($106.5) | |
| Physician Administrative Savings | ($19.8) | |
| Hospital Administrative Savings | ($27.3) | |
| **Managed Care Adjustment** | | |
| Managed Care Adjustment [b/] | | $2.8 |
| **Prescription Drug Rebate** | | |
| Prescription Drug Rebate [b/] | | ($30.2) |
| **Net Change in Health Spending** | | |
| Net Change in Health Spending | | ($118.1) |

a/ Includes all persons in the state including those with public and private coverage.
b/ Assumes an increase in utilization for persons currently covered under HMO plans and an adjustment for higher prescription drug rebates under the government plan.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM)

We estimate that under current trends, about 51,390 Vermont residents would be without health insurance in 2001. We estimate that their use of health services would increase by $23.1 million if they were to become covered under the benefits package described above. Also, utilization would increase among currently insured persons who currently do not have coverage for certain services such as prescription drugs or preventive dental care by about $39.8 million. Thus, the total increase in utilization of heath services among the uninsured and the under-insured persons would be $62.9 million in 2001. In addition, there would be a net increase in spending of about $2.8 million due to changes in the use of managed care under the program. We also assume that the government plan would receive higher prescription drug rebates similar to the current rebates received under the State's Medicaid program. We estimate these rebates to be about $30.2 million in 2001.

The cost of these increases in utilization for uninsured and under-insured persons would be more than offset by reduced administrative costs under the program. The single-payer system replaces the current system of multiple public and private insurers with a single source of payment for all covered services. This eliminates the complexity of both diverse insurer rules and patient billing for unreimbursed amounts. The single-payer system also replaces hospital billing for individual patients with annual operating budgets, which effectively eliminates claims filing functions for Vermont hospitals. (Claims filing would continue for out-of-state patients.)

The single-payer approach would also substantially reduce claims-filing costs for physicians by standardizing the means of reimbursement through a single-payer and by providing full reimbursement through a single source using a standardized electronic claims-filling process. Standardization of coverage would also reduce physician costs related to adjudication of claims and negotiation of selective-contracting arrangements. Total savings to providers would be about $47.1 million. We assume that provider payments are reduced by this amount so that these savings accrue to payers.

The single-payer program would extend large-group economies of scale for administration of insurance throughout the health care system by covering all individuals under a single insurance mechanism. This would eliminate the costs associated with underwriting, transition in coverage, and maintaining the linkage between employers and insurers. Overall, statewide insurer administrative costs would be reduced from $173 million under current policy to $67 million under the single-payer model for a net savings of about $106.5 million in 2001.

## Impact on Employers

Health coverage for workers and their dependents under the single-payer model would be financed with a payroll tax, two-thirds of which would be paid by the employer with the rest paid by the worker. There would be no premiums for the benefits provided under the standard benefits package. We estimate that the payroll tax rates required to fully fund benefits for workers and dependents under the single-payer model would be 5.8 percent for employers and 2.9 percent for employees.

Under these tax rates, total employer health spending in Vermont would increase by $123.2 million in 2001 (***Table ES-2***). This includes $119.6 million in payments by firms that currently do not offer coverage. Employer health spending for firms that currently offer health insurance to their workers would increase by about $3.6 million. Currently insuring firms would realize savings attributed to reduced spending for retirees as Medicare beneficiaries are shifted from their current Medicare benefits plan to the more comprehensive benefits package provided under the single-payer model. Employer costs would increase by an average of $1,452 per worker for workers in firms that do not now offer coverage while costs for firms that currently offer coverage would increase an average of only $20 per worker.

**Table ES-2**
**Change in Private Employer Costs Under the Single-payer Model in Vermont in 2001**

| | Change In Health Spending (in millions) | Change in Health Spending Per Worker |
|---|---|---|
| **Before Wage Effects** | | |
| **Firms That Now Offer Insurance** | $3.6 | $20 |
| **Firms That Do Not Now Offer Insurance** | $119.6 | $1,452 |
| **All Firms** | $123.2 | $479 |
| **After Wage Effects** | | |
| **Firms That Now Offer Insurance** | ($30.1) | ($172) |
| **Firms That Do Not Now Offer Insurance** | $0.0 | $0.0 |
| **All Firms** | ($30.1) | ($117) |

a/ Employers are assumed to pass-on the savings and/or increases in cost under the single payer plan to workers in the form of changes in wages as labor markets adjust to these changes in employee compensation.
Source: Lewin Group Estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

However, economic theory and research indicates that over time increases in employer costs for health and other benefits are typically passed on to workers in the form of reduced wage growth. Thus, we assume that over the long-term, all of the changes in employer costs for workers under the single-payer plan will be passed on to workers in their wages as labor markets adjust to reflect changes in total employee compensation costs under health reform. However, employers are expected to retain any savings in benefits costs for retirees. This is because these savings are attributed to compensation packages for prior workers, which does not affect the labor market for current workers. Overall, private employers would save about $30.1 million in retiree costs under the single-payer model.

## Household Impacts

Under a single-payer program, Vermont residents would no longer pay health insurance premiums and would face only $10.00 copayments for health services. Instead, households would pay taxes on their earnings. In addition, household incomes would be affected by wage adjustments resulting from increased employer spending for health care (i.e., the employer payroll tax). These changes in the way in which care is financed would substantially alter the distribution of health care costs across households of various age and income groups.

We estimate that household health spending would decline by $122.3 million under the single-payer program. This includes the elimination of household premium payments for private health insurance ($321.8 million); and reduced household out-of-pocket payments for health services ($218.8 million). These savings would be offset by increased tax payments of $307 million. In addition, we estimate a loss of wages to households (after tax offsets) of about $111.3 million as employers pass-on the increased cost of complying with the payroll tax to workers in the form of reduced wages.

Overall, we estimate that households would see health spending decrease by an average of about $441 per family under the single-payer model in 2001 ***(Table ES-3).*** In general, the single-payer plan would tend to reduce health care costs for lower- and middle-income families. For example, families with under $75,000 in annual income would, on average, see savings. However, health spending for families with $150,000 or more in income would increase by about $4,490 per family. This reflects the fact that the program shifts Vermont residents away from a premium financed system, to a tax financed system where total health spending would be in proportion to family earnings.

**Table ES-3**
**Change in Average Household Health Spending in Vermont Under the Single-Payer Model in 2001: After Wage Effects** [a/ b/]

| Family Income | Single-Payer |
|---|---|
| **Less than $10,000** | ($608) |
| **$10,000 - $14,999** | ($721) |
| **$15,000 - $19,999** | ($1,000) |
| **$20,000 - $29,999** | ($1,038) |
| **$30,000 - $39,999** | ($1,238) |
| **$40,000 - $49,999** | ($1,397) |
| **$50,000 - $74,999** | ($995) |
| **$75,000 - $99,999** | $58 |
| **$100,000 - $149,999** | $933 |
| **$150,000 or More** | $4,490 |
| **All Families** | ($441) |

a/ Excludes institutionalized persons.
b/ Includes changes in premiums, out-of-pocket expenses, taxes earmarked to fund health reform, and after-tax wage effects.
Source: Lewin Group Estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

Savings under the single-payer plan would tend to be greatest for older individuals. For example, families headed by an individual age 65 or older would save about $1,575 per family ***(Table ES-4)***. By contrast, average health spending would increase by up to $259 per family for younger age groups. On average, household savings would be greatest for families facing high out-of-pocket costs under current policy.

**Table ES-4**
**Change in Average Family Spending on Health Care in Vermont Under the Single-Payer Model in 2001 by Family Income and Age of Household Head: After Wage Effects** [a/ b/]

| | Average Change by Age of Householder | | |
|---|---|---|---|
| **Family Income** | **Under Age 65** | **Age 65 and Older** | **All Families** |
| **Less than $10,000** | ($450) | ($1,006) | ($608) |
| **$10,000 - $14,999** | ($296) | ($1,396) | ($721) |
| **$15,000 - $19,999** | ($543) | ($1,961) | ($1,000) |
| **$20,000 - $29,999** | ($837) | ($1,567) | ($1,038) |
| **$30,000 - $39,999** | ($1,001) | ($2,482) | ($1,238) |
| **$40,000 - $49,999** | ($1,232) | ($2,351) | ($1,397) |
| **$50,000 - $74,999** | ($853) | ($2,081) | ($995) |
| **$75,000 - $99,999** | $229 | ($1,928) | $58 |
| **$100,000 - $149,999** | $1,191 | ($1,732) | $933 |
| **$150,000 or More** | $4,861 | $(357) | $4,490 |
| **All Families** | **($171)** | **($1,575)** | **($441)** |

a/ Excludes institutionalized persons.
b/ Includes changes in premiums, out-of-pocket expenses, taxes earmarked to fund health reform, and after tax wage effects.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

## I. INTRODUCTION

The purpose of this analysis is to explore the expected costs and impacts of universal health care coverage for residents of Vermont under a single-payer approach. In general terms, the single-payer model is one where all individuals in the state are covered under a single uniform health plan that is administered and funded by the state. The new single-payer system would replace all current public-sector insurance systems including: Medicare, Medicaid, CHAMPUS and the Federal Employees Health Benefits Plan (FEHBP). It would also replace private health insurance plans in the state. The program would be financed with current government health care funding for discontinued programs, and new taxes on employer payroll.

In this report, we analyze the financial impact of the single-payer model on various payers for health care including state, local, and federal governments. We also estimate the financial impact of the proposal on employers by industry and firm size. In addition, we estimate the impact of the plan on household health spending by age, income level, and other characteristics.

Our analysis is presented in the following sections:

? Overview of the Single-Payer Model;

? Vermont Health Spending under the Single-Payer Model;

? Government Spending under the Single-Payer Model;

? Changes in Employer Health Spending; and

? Impact of a Single-Payer Model on Household Health Spending.

## II. A SINGLE-PAYER PROGRAM FOR VERMONT

The Vermont single-payer program is modeled after a program designed by the Maryland Citizens' Health Initiative Education Fund, Inc. This program would provide universal access to health care coverage for all Vermont residents. All Vermont residents would obtain coverage through a single state operated program including those now covered under existing public and private health insurance programs.[2] Vermont residents would no longer have to purchase private health insurance through their employer or on their own in the individual insurance market. Persons now covered under Medicare, Medicaid, CHAMPUS, and the Federal Employees Health Benefits Program (FEHBP) would be covered under the single-payer plan.

### A. Benefits Package

The single-payer benefits package would be modeled on the benefits typically provided under employer health plans. The program would cover medically necessary inpatient hospital care, physician services (including preventive care), hospital outpatient care, prescription drugs, lab tests, and mental health services (including substance abuse and tobacco cessation). Chiropractic services would be covered when referred by a physician. The program would cover preventive dental care and vision exams, but it would not cover orthodontia, private rooms, or eyeglasses. To discourage over-use of services, there would be a $10.00 copayment for ambulatory care services and no deductible.

Benefits that are currently provided to Medicaid-eligible persons that are not covered under the single-payer model would be continued for low-income persons who qualify for Medicaid under current eligibility rules. These benefits include long-term care, eyeglasses, corrective dental care, orthodontia and transportation. Coverage for home health and nursing home services would also be continued as a benefit for persons who qualify under current Medicaid rules. (The existing Medicaid "spend down" rules for Medicaid would be retained for long-term care.)

We assume that all Medicare beneficiaries in Vermont would become covered under the state program. For Medicare recipients, the single-payer program would cover both services now covered under Medicare and a substantial portion of costs that are not now covered by Medicare such as outpatient prescription drugs, and Medicare cost sharing amounts. We assume that Medicare beneficiaries would continue to pay the Medicare Part-B premium.

We also assume that employers would continue to provide workers with coverage for those services that they now cover that would not be provided under the single-payer model. These will typically include orthodontia and eyeglasses.

### B. Managed Care

The Vermont single-payer program would feature a primary care provider referral (i.e., gatekeeper) model. Primary care providers would be paid a fee to coordinate patient care for patients with chronic illnesses. Specialist visits without a referral would be covered subject to a 50 percent copayment. Women would be permitted to select a gynecologist as their primary care

[2] To minimize instances where out-of-state residents temporarily move to Vermont to obtain coverage when they become ill, individuals are required to have been a Vermont resident for at least one month.

provider, if agreeable to the physicians, in recognition of their unique health care needs. With the exception of the primary care provider referral model, most other managed care practices would be eliminated. This includes prior authorization, physician profiling, and network formation and recruitment. We assume that the program would continue to perform retrospective utilization review to protect against fraud and abuse as is done in modern indemnity plans.

The impact that these changes in the use of managed care would have on utilization, are mixed. Persons who are currently in fee-for-service plans may actually see a reduction in utilization due to the use of the primary care provider referral model. Conversely, persons enrolled in restrictive HMOs would probably tend to experience a net increase in utilization. Our assumptions on the impact of these changes in care delivery are discussed in Appendix A.

## C. Program Administration

The single-payer model would streamline administration of health benefits by centralizing the source of payment for all covered health services under a single program with uniform coverage and reimbursement rules. This would reduce administrative costs for both the insurer function and for providers. We also assume that the Vermont single-payer model would replace hospital billing for individual patients with annual operating budgets. The hospital budgeting model is designed to eliminate the costs of negotiating selective-contracting discounts with providers and eliminate many of the utilization management programs now used by private insurers. However, many of these costs would remain for care provided to non-state residents in Vermont and for services provided to Vermont residents receiving services out-of-state.

## D. Health Spending Budgets

In each year, the single-payer program would establish a global budget for health services covered under the program. In the first year of the program, we assume that health spending would equal what total health spending would have been in the state under current trends. However, these amounts would be adjusted to reflect the unique features of the program. These adjustments include:

? Health expenditures would be adjusted to reflect the increase in utilization for persons who otherwise would have been uninsured or underinsured;

? Spending would be adjusted to reflect the changes in utilization resulting from the fact that there would be no HMO coverage under the program; and

? Spending also would be adjusted to reflect that fact that providers would now receive payment for services that otherwise would have been treated as uncompensated care, thus, eliminating the “cost shift” for uncompensated care.

Operating budgets for hospitals would be set equal to the amount of spending that would have occurred in Vermont hospitals under current trends plus an allowance for changes in utilization

under the single-payer program. These budgets would be adjusted downward to reflect the anticipated reduction in provider administrative costs under the single-payer model.

Fee-for-service (FFS) payments to physicians and other providers would be equal to the overall weighted average of payments to providers from all sources under the current system. However, payment to all FFS providers would be reduced to reflect the reduction in uncompensated care expenses due to universal coverage and the expected reduction in provider administrative costs resulting from the use of a single-payer system.

By establishing a single-payer program, the state would effectively determine health-spending levels in Vermont by setting hospital budgets and provide reimbursement levels. These budgets could be used as a means of capping the rate of growth in health spending throughout the state. However, for illustrative purposes, we assume that health spending is budgeted to increase at the same rate as it would have increased under current trends.

## E. Financing

The program would have two sources of financing. First, the program would recover all state, local and federal funds used to provide health services under the current system that would become covered under the single-payer program. This would include state and federal funding for Medicaid, and the State Children's Health Insurance Program (SCHIP) for those services covered by the single payer program (We assume that Medicaid would be retained for long term care which would not be covered under the single payer program). It would also include federal funding for Medicare and CHAMPUS.

The second source of financing would be a payroll tax. The payroll tax rate would be set at the level required to fully fund the remaining expenses for the program. Two-thirds of the payroll tax would be paid by the employer and the remaining third paid by the worker. However, employers would be permitted to pay a larger share of the payroll tax. The payroll tax would vary automatically as program costs and the wage base changes over time.

## F. Vermont Residents Employed Out-of-State

One problem with implementing a payroll tax finance program for Vermont is that some residents work for employers that are located out-of-state. These employers are beyond the reach of the state's taxing authority. Consequently, out-of-state employers cannot be required to pay the employer's share of the payroll tax. However, the state would be able to collect the employee share of the payroll tax through the withholding process used for the existing income tax (i.e., employers routinely withhold taxes for workers who live out of state).

For purposes of this analysis, we assume that Vermonters who are employed out-of-state are permitted to take coverage for themselves and their dependents through their employer.[3] These individuals are excused from the employee share of the payroll tax and would not be eligible for coverage under the Vermont single-payer program. To assure that all persons take their

[3] In two worker families where one workers is employed out-of-state and the other works in Vermont, the Vermont worker is required to be covered under the Vermont program and must pay the payroll tax.

employer's coverage, out-of-state workers would be required to present proof of coverage with their tax returns or be liable for both the employee and employer shares of the payroll tax.

In fact, many out-of-state employers are likely to voluntarily pay the employer share of the payroll tax. This is because paying the payroll tax for a worker will often be less than the cost of providing the insurance that that they now sponsor. In these instances, we expect that many employers will simply substitute the payroll tax payment for the health insurance policy that they are now providing for these workers. For illustrative purposes, we assume that all out-of-state employers, who now offer coverage, respond by substituting the employer payroll tax payment for the health plans that they now provide to their Vermont workers.

However, workers who are employed outside of the state by an employer that does not provide coverage would be covered under the Vermont single-payer plan. These individuals would pay the employee's share of the payroll tax plus a portion of the employer's share of the payroll tax which would vary with income from zero dollars for families with incomes below $40,000 to the full amount of the employer payroll tax for persons in families with incomes above $100,000. We anticipate that there will be very few workers employed out-of-state with incomes over $40,000 whose employer does not provide coverage.

As discussed above, we assume that all Federal workers living in Vermont would be covered under the single-payer program. We assume that the Federal Government would agree to pay the payroll tax for Vermont employees in exchange for no longer covering these individuals under the FEHBP. Thus, the only Vermont residents excluded from the single-payer program would be private sector workers (and their dependents) with out-of-state employers who provide coverage.

## III. ESTIMATING THE IMPACT OF THE SINGLE-PAYER MODEL IN VERMONT

In this analysis, we estimated the financial impact of the single-payer model on major payers for health care in Vermont including state and local governments, employers, households and federal government. In particular, we estimated the distributional impact of this proposal on various subgroups of payers such as small employers and families in various age and income groups. These estimates were developed using the Lewin Group Health Benefits Simulation Model (HBSM) that is specifically designed to provide these detailed distributional impact analyses for state-level health reform initiatives.

In this section, we describe the data and methods used in HBSM to develop estimates of the impact of the single-payer initiative in Vermont. We begin by describing the overall methodology used in the model. We then explain how the model was adapted to provide Vermont specific estimates of the impact of this bill on health spending by various payers in future years. Our discussion is presented in the following sections:

? Overview of HBSM

? Health Spending in Vermont

? Projections to Future Years

### A. The Health Benefits Simulation Model

HBSM is a "microsimulation" model of health spending. The core for the model is a representative sample of Vermont households. For each household in the sample these data provide information on health insurance coverage, health spending, income, employment and basic demographic characteristics. The model uses these data to show how expenditures for households will change as they become covered under a new health insurance system such as the Vermont single-payer program. This micro level approach of simulating changes in spending for individual households permits us to estimate both the aggregate impact of major health reform initiatives as well as the impact on households of various socioeconomic groups.

For example, the model estimates the increase in utilization that will occur as coverage is extended to previously uninsured persons. The model also determines which of the services for each individual are covered under the plan, the reimbursement amount for these services under the plan's cost sharing rules, and savings to the sources of payment for this care under current law (family out-of-pocket, employers, county hospitals, charity care, etc.). Because the model is based upon a representative sample of the population, it produces aggregate estimates of the impact of policy proposals on total number of persons affected, aggregate health spending, and program costs. However, because the model develops these estimates based upon analyses performed on an individual-by-individual basis, the model also provides estimates of the impact of these policies on various socioeconomic groups.

Using these data, HBSM produces estimates of program impacts by source of payment including:

? Employer Impacts

- Number of workers and dependents affected
- Cost to employers
- Impact on firms that do not now insure
- Number of firms affected
- Uncompensated care cost shift savings
- Tax savings (corporate deductions for health benefits, if applicable)

? Provider Impacts

- Utilization by type of service/provider
- Sources of payment for care
- Expenditures for services by type of service/provider
- Hospital uncompensated care

? Household Impacts

- Number of insured by income, age, sex, etc.
- Family premium payments
- Family out-of-pocket spending

? Government Impacts

- Expenditures under Medicaid expansions
- Offsets to general assistance
- Offsets to public hospitals
- Corporate income tax losses
- Tax revenues under various financing mechanism

The basic data source used in this analysis is the 2000 Vermont family health insurance survey. This survey provides information on the distribution of Vermonters by source of insurance, income, age, and employment status. These data are supplemented with additional information provided in the Vermont sub-sample of the March Current Population Survey (CPS) conducted by the Bureau of the Census. ***Figure 1*** shows the distribution of Vermont residents by primary source of insurance in 2000.[4]

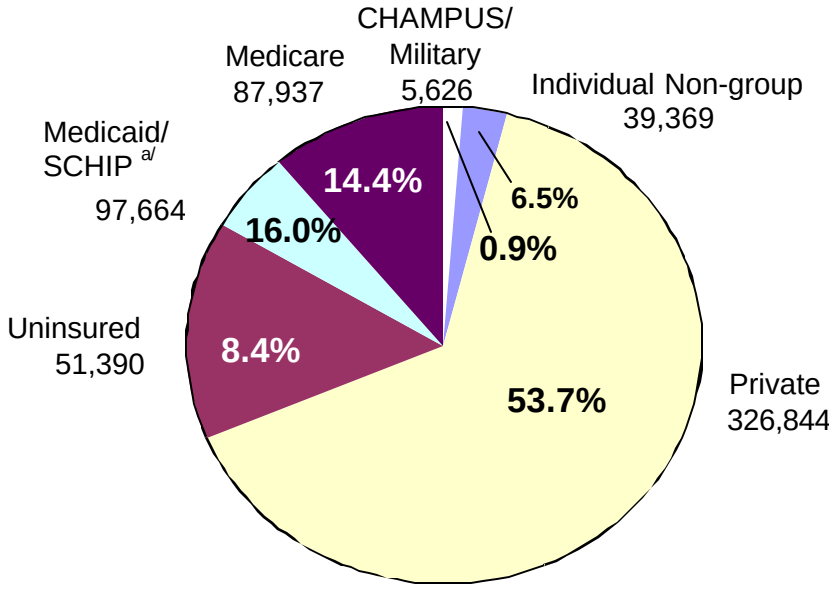
Because the CPS does not include health spending data, we merged the Vermont subsample of the CPS with the 1996 Medical Expenditures Panel Survey (MEPS) data which includes health care utilization and expenditures data for households across various income, age and employment status groups. The population and income data in the database were adjusted to 2001 based upon the best available projections for that year. Health expenditure data were then controlled to replicate aggregate health expenditures estimates for 1998 by type of service and

[4] Because of the relatively small sample size for specific demographic groups in the CPS at the state-level, we 'pooled' the most recent four years (1997-2000) of CPS data for Vermont.

source of payment derived from statewide health expenditures estimates developed by the Vermont Division of Health Care Administration.

**Figure 1**

**Distribution of Persons in Vermont by Primary Source of Insurance Coverage in 2001 (Average Monthly Coverage Estimates: in thousands)**




**Number of Persons: 608,830**

a/ The 2000 survey of Vermont households reports 366,213 persons with private insurance of which we estimate about 11 percent are persons with non-group coverage.

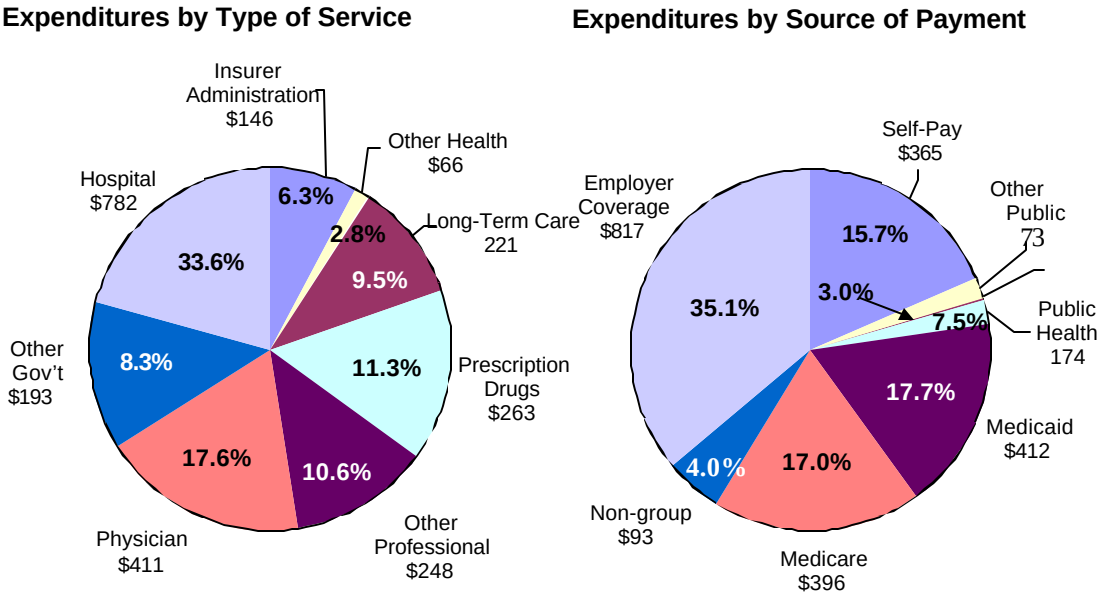
Source: Vermont Division of Health Care Administration 2000 Vermont Family Health Insurance Survey July 2001.

## B. Projections Through 2001

The household database was "aged" to be representative of the Vermont state population in 2001. This was accomplished by adjusting the population totals in these data to reflect trends in population growth by age and sex. The earnings and other income data reported in the household database were also adjusted to reflect income growth projections. Finally, health expenditures were adjusted to reflect projections of health spending by type of service and source of payment.

The population totals were adjusted to reflect Bureau of the Census projections of population levels by age and sex in Vermont through 2001. We also adjusted the Medicaid coverage data to reflect federally mandated expansions in coverage for children through 2001 based upon data provided by the VHAP program. ***Figure 2*** presents these estimates of Vermont health spending by type of service and source of payment.

**Figure 2**
**Health Expenditures for Vermont Residents by Type of Service and Source of Payment in 2001 (in millions)**




**Total Health Expenditures = $2,330**

Source: Estimates provided by the Vermont Division of Health Care Administration

We adjusted the incomes reported by individuals in the database to future years. Earnings were adjusted based upon historical data on real growth in earnings per worker. Non-earnings income was projected based upon the historical rate of growth in non-earnings income per person. These growth estimates were adjusted to be consistent with national income projections provided by the Congressional Budget Office (CBO).

## IV. CHANGES IN AGGREGATE HEALTH SPENDING UNDER A SINGLE-PAYER PROGRAM

As discussed above, we estimate that total spending for health care services would be $2.2 billion in 2001. This includes total spending for acute care and long-term care services including benefits payments and administration. In this analysis we estimated the change in overall spending for health services in Vermont under a single-payer plan over the 2001 through 2010 period. We estimated the change in provider revenues and insurer administrative costs as well as changes in spending for major payers for health care including employers, households and governments.

Our analysis of the impact of a single-payer plan on health spending in Vermont is presented in the following sections:

? Changes in Health Spending;

? Health Spending by Major Payers for Care; and

? Health Spending in Future Years.

### A. Changes in Health Spending

We estimate total health spending in Vermont under the single-payer plan in 2001 would be about $118.1 million less than what spending would be under current trends (***Table 1***). This includes an increase in health services utilization for newly insured persons that would be more than offset by a net reduction in administrative costs and other savings.

#### *1. Health Services Utilization*

Health services utilization in Vermont would increase under a single-payer plan as comprehensive health care coverage is extended to all individuals. In particular, increased utilization is expected among the 51,390 persons who otherwise would be uninsured in 2001.

We assume that under a program of universal insurance coverage, use of health services for those who would otherwise be uninsured will increase to levels reported by insured persons with similar age, sex, income and self-reported health status characteristics. Based on this assumption, we estimate that the net increase in health spending for previously uninsured person would be about $23.1 million. This is an estimate of the net change in utilization for this group that reflects reduced hospitalizations for preventable conditions offset by increased utilization of preventive care and increased use of elective procedures.

## Table 1
## Changes in Health Spending in Vermont under the Single-Payer Proposal in 2001 (in millions) [a/]

| | | Changes in Spending |
|---|---|---|
| **Changes in Health Services Utilization** | | |
| Increase in Utilization Due to Expanded Coverage | | $62.9 |
| Utilization Increase for Previously Uninsured [b/] | $23.1 | |
| Expanded Coverage for Those Already Insured [c/] | $39.8 | |
| **Change in Administrative Costs** | | |
| Net Change in Administrative Costs | | ($153.6) |
| Insurer Administration (Includes Administration for Newly Insured) [d/] | ($106.5) | |
| Physician Administrative Savings [e/] | ($19.8) | |
| Hospital Administrative Savings [e/] | ($27.3) | |
| **Change in Provider Reimbursement** | | |
| Net Change in Provider Reimbursement [f/] | | $0.0 |
| New Revenue for Previously Uncompensated Care | $50.0 | |
| Reduction in Cost Shift | ($50.0) | |
| **Managed Care Adjustment** | | |
| Managed Care Adjustment [g/] | | $2.8 |
| **Prescription Drug Rebate** | | |
| Prescription Drug Rebate [h/] | | ($30.2) |
| **Net Change in Health Spending** | | |
| Net Change in Health Spending | | ($118.1) |

a/ Includes spending for acute care. Excludes research, construction long-term care and public health.

b/ Assumes that utilization of health services by previously uninsured persons will rise to the levels reported by insured persons with similar age, sex, income and health status characteristics.

c/ Assumes that utilization of newly covered health services for insured persons whose coverage is upgraded (prescription drugs, etc.) will rise to the levels reported by persons who have such coverage.

d/ Total insurer administrative costs are estimated to be $173 million in 2001. Insurer administrative costs will drop to $67 million under the single-payer model. We estimated single-payer program administrative costs based upon Medicare program administrative costs adjusted for the unique features of the single-payer plan.

e/ Savings in provider administrative costs result from: uniform billing procedures, elimination of patient billing, for cost sharing amounts, and the use of hospital capital and operating budgets. For a discussion of the methodology used see: John F. Sheils et al., "National Health Spending Under a Single Payer System: The Canadian Approach," Lewin-VHI, January 8, 1992.

f/ Under a universal coverage program, hospitals and physicians will receive payments for care formerly provided as uncompensated care. We assume that provider payments are adjusted to eliminate provider windfalls for care already paid for through cost shifting.

g/ Assumes a 4.0 percent increase in utilization for persons formerly enrolled in HMOs.

h/ Assumes a 17.9 percent rebate on prescription drug expenses covered under the program, which is the same percentage drug rebate received by the Vermont Medicaid Program. Rebates for privately insured persons under the current system are assumed to be equal to 8.3 percent.

Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

There also would be an increase in utilization for previously underinsured persons. Many insured individuals do not have coverage for some of the services that would be covered under the uniform benefits package. For example, many plans do not cover prescription drugs, and preventive dental care. We assume that utilization of these services would increase to levels reported by persons who have coverage for these services with similar age, sex, income and health status characteristics. The net increase in spending for the underinsured would be $39.8 million in 2001.

### *2. Administrative Costs*

The single-payer system streamlines health care administration by centralizing the source of payment for all covered health services under a single governmental program with uniform coverage and reimbursement rules. The proposal also eliminates patient cost sharing (i.e., deductibles and coinsurance) for most services, thus, eliminating the cost of billing patients for amounts that are not covered by insurance.

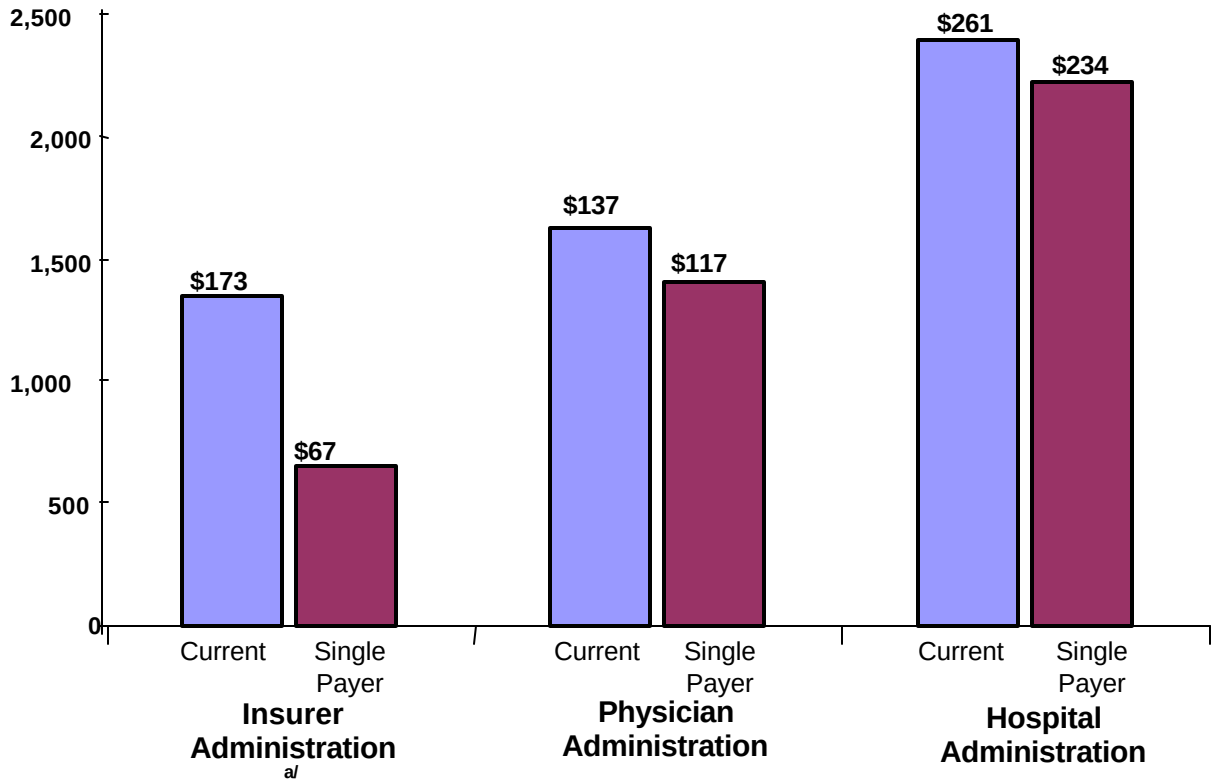
The single-payer system replaces the current system of multiple public and private insurers with a single source of payment for the full amount of covered services. This eliminates both the complexity of diverse insurer rules and patient billing for unreimbursed amounts. The single-payer system also replaces hospital billing for individual patients with annual operating budget, which effectively eliminates claims filing functions for Vermont hospitals. (Claims filing would continue for out-of-state patients and patients with private supplemental coverage.)

We estimate that insurer administrative costs in Vermont would be $173 million in 2001 under current law. This includes administration for private insurance and public programs. The cost of insurance administration includes the cost of processing claims, research, utilization review, and determining eligibility under government programs. Administrative overhead for private insurers also includes these costs plus marketing costs, taxes, net reserve accumulations and profits.

The single-payer program would extend large-group economies of scale throughout the health care system by covering all individuals under a single insurance mechanism. This would eliminate the costs associated with underwriting, transition in coverage, and maintaining the administratively cumbersome linkage between employers and insurers. Overall, statewide insurer administrative costs would be reduced from $173 million under current policy to $67 million under the single-payer model for a net savings of about $106.5 million in 2001 ***(Figure 3).***

**Figure 3**

**Changes in Administrative Costs Under the Vermont Single-Payer Program for Insurance and Health Care Providers: 2001 (in millions)**




a/ Insurer administrative costs under current policy are based upon data provided by The Vermont Division of Health Care Administration for 1998 which we projected to 2001 using the Vermont version of the Health Benefits Simulation Model (HBSM).

b/ Estimates of provider administrative costs and savings are based upon John F. Sheils and Gary J. Young, "National Health Spending Under a Single payer System", The Lewin Group, January 8, 1992.

Source: Lewin Group Estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

The Lewin Group has conducted analyses of the impact of a single-payer program for the US, which were based upon a detailed analysis of the data available on physician practice expenses.[5] In this analysis, we estimated that about 32 percent of physician revenues ($137 million in 2001) are devoted to administrative functions. Physician administrative costs include all physician overhead expenditures attributed to activities other than those directly related to patient care such as business office staff and the value of physician time devoted to practice management and insurer-related functions.

The single-payer approach would substantially reduce claims-filing costs for physicians by standardizing the means of reimbursement through a single-payer and by providing full

[5] For a detailed discussion of the methods used in this analysis see: Sheils, et al., "O Canada: Do We Expect Too Much From Its Health System", *Health Affairs*, Spring 1992; and Sheils, et al., "National Health Spending Under a Single-Payer System: The Canadian Approach: Staff Working Paper", The Lewin Group, January 1992.

reimbursement through a single source using a standardized electronic claims-filling process. Standardization of coverage would also reduce physician costs related to adjudication of claims and negotiation of selective-contracting arrangements. In a prior Lewin Group analysis of a single-payer program for the US, we estimated that the single-payer model would reduce physician administrative costs by about 19 percent under a plan with minimal copayments (e.g., $10.00 per visit). We estimate that physician administrative costs in Vermont would be reduced by about 14 percent ($19.8 million) in 2001.

We estimate that Vermont hospitals would spend about $261 million (33.4 percent of revenues) on administration in 2001. This is based upon a Lewin Group analysis of cost data for hospitals, which was conducted as part of our above-referenced single-payer study. In this analysis, we define hospital administrative costs to include all labor and overhead expenditures attributed to functions other than those directly related to patient care, such as accounting, credit and collections, and admitting. The single-payer proposal would all but eliminate hospital administrative costs associated with filing claims because under the single-payer model, hospitals are given an annual operating budget covering all services provided by the hospital. However, hospitals would still need to submit claims for out-of-state patients. Based upon our prior analyses of hospital data, we estimate that hospital administrative costs would be reduced by about ten percent ($27.3 million) in 2001 under the single-payer model.

### *3. Changes in Provider Payment*

Due to the fact that all Vermont residents would have coverage, uncompensated care costs would be largely eliminated for all types of providers including hospitals, physicians and other professionals. However, Vermont providers would continue to incur uncompensated care costs for out-of-state individuals obtaining care in Vermont. We estimate that provider uncompensated care costs would be reduced by about $50 million in 2001 under the single-payer system (includes savings to hospitals and other providers). As discussed above, we assume that provider payment rates that currently reflect the cost of uncompensated care would be reduced so that there is no net change in provider reimbursement. The global expenditure budget also would be adjusted to reflect the increase in utilization expected among persons who would have been covered under HMOs under current policy. This adjustment is assumed to be equal to an increase of about 4.0 percent among these individuals. This represents an increase in spending of about $2.8 million 2001.

Finally, we anticipate that the single-payer program would be able to secure increased rebates from prescription drug companies for prescriptions purchased for Vermont residents. We assume that the program would receive the same percentage rebate that Medicaid receives under the current program, which is 17.9 percent. This is more than double the average rebate typically negotiated by private carriers, which we estimate to be about 8.3 percent. We estimate that net rebate savings would be about $30.2 million in 2001.

***Table 2*** presents our estimates of the net change in provider payments by type of provider under the single-payer model. Overall, payments to providers would increase $18.6 million. This estimate reflects the increase in utilization for persons who are currently uninsured or under-insured and various adjustments in provider payments to reflect reduced provider administrative

burdens and reduced uncompensated care costs. This net increase in provider payments would be offset by a reduction in insurer administrative costs of $106.5 million and prescription drug rebates of $30.2 million so that the net impact of the program would be a reduction in total health spending of $118.1 million.

**Table 2**
**Changes in Provider Payments and Insurer Administrative Costs Under the Vermont Single-Payer Program: 2001 (in millions)**

| Type of Service | Current Spending | Change in Spending | Percent Change in Spending |
|---|---|---|---|
| Hospital Inpatient | $470 | ($8) | (1.7%) |
| Hospital Outpatient | $297 | ($6) | (2.0%) |
| Physician & Other Professionals | $708 | $8 | 1.1% |
| Prescription Drugs | $341 | ($6) | (1.8%) |
| Long-Term Care | $239 | n/a | n/a |
| Other Health Services | $35 | n/a | n/a |
| Total Provider Payments | $2,090 | ($12) | 0.6% |
| Insurer Administration | $173 | ($106) | (61.3%) |
| **Total** | **$2,263** | **($118)** | **(5.2%)** |

a/ See ***Table 1*** for detailed summary of changes in statewide health spending.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM)

## B. Health Spending by Major Payers for Care

A single-payer plan would substantially change aggregate health spending for governments, employers, and households. As discussed above, we estimate that overall health spending in Vermont would be reduced under the single-payer model by $118.1 million in 2001 **(*Table 3*)**. Because the tax rates under the single-payer program would be set at levels sufficient to fund the program, the state costs of the program would be roughly offset by revenue collections. We also estimate that there would be no net change in federal health spending. This is because we assume that the federal government would simply transfer to the program the full amount of what would have been spent under federal programs (i.e., Medicare, Medicaid, etc.) to the Vermont single-payer program with no net change in federal expenditures.

Private employers would see a net increase in health spending of $123.2 million. This includes an increase of $119.6 million for firms that do not now offer insurance. It also includes a $33.7 million increase in spending for workers and their dependents in firms that currently provide health insurance which means that payroll tax payments would on average be greater than what would have been paid for benefits under current policy. However, this increase in costs for workers and dependents for firms that now offer coverage would be nearly offset by reduced spending for retirees. These savings occur because the single-payer program would cover most of the expenses for services that are now covered by retiree health plans (e.g., prescription drugs, Medicare copayments, etc.).

**Table 3**
**Changes in Health Spending in Vermont under the Single-Payer Proposal in 2001**
**(in millions)**

| | Before Wage Effects | After Wage Effects |
|---|---|---|
| **Changes in Health Spending** | | |
| **State Government Health Spending** | ($7.7) | **- - -** |
| Total Program Costs | $1,557.4 | $1,557.4 |
| Program Revenues | ($1,565.1) | ($1,565.1) |
| Tax Loss (Gain) | - - - | $7.7 |
| **Federal Government Health Spending** | **- - -** | **$34.3** |
| Transfers to Program | $569.1 | $569.1 |
| Current Program Spending | ($558.8) | ($558.8) |
| Employee Benefits | $10.1 | $10.1 |
| Tax Loss (Gain) | - - - | $34.3 |
| **Private Employer Health Spending** | **$123.2** | **($30.1)** |
| Firms that Now Insure | ($3.6) | ($30.1) |
| Workers and Dependents | $33.7 | - - - |
| Retirees | ($30.1) | ($30.1) |
| Firms that Do Not Now Insure | $119.6 | - - - |
| **Household Health Spending** | **($233.6)** | **($122.3)** |
| Premium Payments | ($321.8) | ($321.8) |
| Dedicated Tax Payments | $307.0 | $307.0 |
| Out-of-Pocket Payments | ($218.8) | ($218.8) |
| After-Tax Wage Loss (Gain) | - - - | $111.3 |
| **Net Change in Health Spending** | | |
| **Net Change in Spending** [a/] | **($118.1)** | **($118.1)** |

a/ See ***Table 1*** above for a detailed summary of changes in statewide health spending. Includes changes in wages and tax revenues.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

Aggregate household spending for health care would be reduced by $233.6 million under the program. Savings to households would be attributed to the elimination of premium payments ($321.8 million) and reductions in household out-of-pocket payments ($218.8 million). These savings would be largely offset by payroll tax payments of about $307 million resulting in net savings to households of $233.6 million.

Both economic theory and empirical research indicate that over time most of the increased costs to employers resulting from the payroll tax would be passed-on to employees in the form of reduced wages.[6] This wage loss would offset health expenditure savings for households which

[6] We assume that wages are reduced for all private sector employees but that there would be no change in wages for government workers.

would reduce net savings to households to about $122.3 million under the program. We also estimate that the state and federal governments would lose income tax revenue as wages are reduced. However, savings for retiree coverage would accrue fully to the employer because these benefits are part of the company's compensation costs for past employees and should have no impact on wages for current employees.

The impact of a single-payer plan on major payers for health care is discussed in greater detail in the following sections.

## C. Health Spending in Future Years

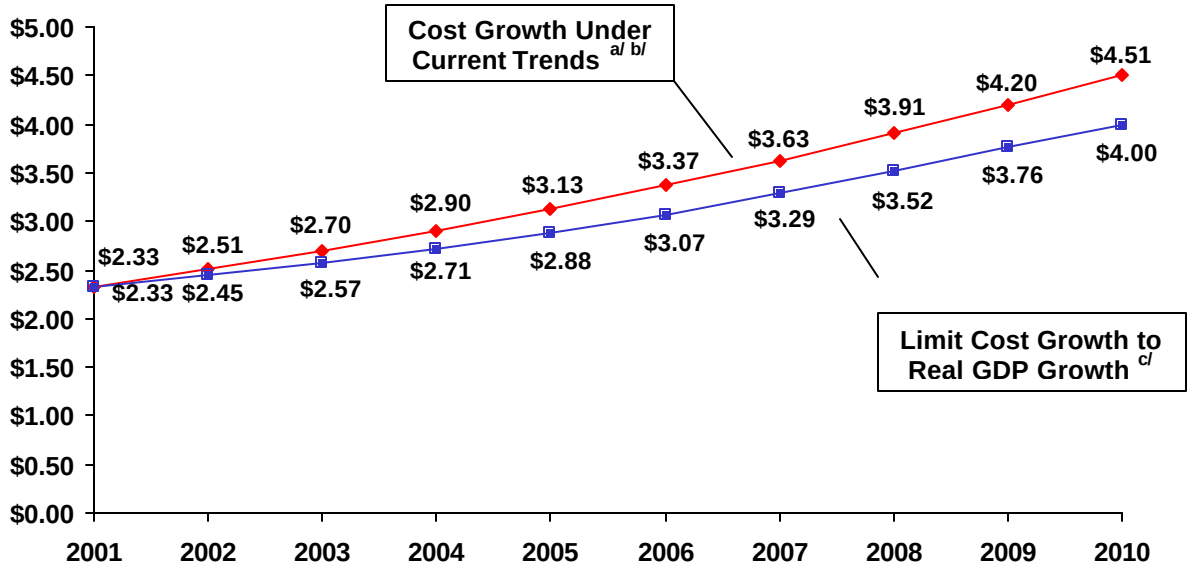
Under the single-payer model, the state would effectively determine the level of spending for health care in Vermont. This is because the single-payer program would set hospital spending levels through explicit budgets for each hospital and would determine the levels of reimbursement for individual health services. Consequently, the state will need to develop a forum for determining the allowable rates of growth in spending under the program. Indeed, the budgeting process for the single-payer program is likely to emerge as a powerful cost containment tool.

The Health Care Financing Administration (HCFA) projects that real per-capita health spending (i.e., cost growth in excess of population growth and general price inflation) will grow nationally at a rate of 3.1 percent per year through 2010. This is about 1.9 percentage points faster than the projected rate of growth in income as measured by the real per-capita rate of growth in the GDP (expected to be about 1.2 percent).

If costs were permitted to grow at this rate, health spending in Vermont would increase from $2.33 billion in 2001 to $4.51 billion by 2010 (***Figure 4***). However, because health care costs are projected to grow faster than GDP (i.e., statewide income), the tax rates required to fully fund the program would increase each year. Under current health spending and GDP growth assumptions, the payroll tax required to fund the single-payer model (discussed below) would increase from our estimate of 8.7 percent in 2001 to 10.3 percent by 2010.

To prevent this increase in tax rates, the state could set limits on provider reimbursement levels, which slow the rate of growth in health spending. For example, reimbursement amounts could be set at levels where real per-capita state health spending grows no faster than the growth in real per-capita state GDP (i.e., 1.2 percent per year). Under this scenario, health spending in Vermont in 2010 would be about $500 million less than currently projected (***Figure 4)***. At this slower rate of growth, the payroll tax rate would remain at 8.7 percent throughout the next decade.

**Figure 4**
**Total Health Spending in Vermont Under Alternative Cost Growth Scenarios**
**(In billions)**




a/ Assumes current cost growth forecasts of real per-capita cost growth of 3.1 percent per year.
b/ Excludes spending for research and construction, public health and long-term care.
c/ Assumes that the rate of growth in health spending is constrained so that it does not exceed the rate of growth in real per-capita GDP (1.2 percent per year).
Source: Based upon Vermont projections of health spending in Vermont developed by the Division of Health Care Administration

However, it is unclear whether $500 million can be removed from the health sector without slowing the adoption of medical technology or otherwise compromising the quality of care. Thus, the state will need to balance the need to control costs against the need to assure high quality health care in Vermont. This will require establishing a process for monitoring health care quality and a forum for discussing and adopting the appropriate levels of cost growth.

## V. GOVERNMENT SPENDING UNDER THE SINGLE-PAYER MODEL

Under a single-payer program, a new state-run independent agency would be responsible for financing almost all acute care services in Vermont. This will have significant implications for health spending by all levels of government including the state, local governments and the federal government. The impact of a single-payer plan on government finances is discussed in the following sections:

? State Program Expenditures

? Federal Government Expenditures

### A. State Program Expenditures

***Table 4*** presents our estimates of the sources and uses of funds under the government single-payer program. Total expenditures under the program would be about $1,557.4 million in 2001. This includes the cost of all benefits payments and the cost of administering the program. The program would be fully funded with the funds that would have been spent for health care under existing government programs and revenues from dedicated taxes created to finance the program.

#### *1. Program Expenditures*

As discussed above, the program would be designed so that in the first year of the program, provider payment levels would be equal to the average payment levels for covered services in the current system (i.e., averaging across Medicare, private insurance, etc.), adjusted to reflect the unique features of the program. Total benefit payments before adjustments would be $1,705.5 million, which reflects the increase in utilization for previously uninsured persons discussed above. However, payment levels would be adjusted as follows:

? Uncompensated Care Savings – Provider payment levels would be reduced to reflect the fact that providers will receive payments for services that would have been counted as uncompensated care under current policy. This adjustment lowers payment levels per unit of service so that the overall average payments for service remain the same as under current policy;

? Provider Administration – Payments to providers would be reduced to reflect the expected reductions in provider administration;

? Managed Care Adjustment – spending levels would be permitted to increase by $2.8 million to reflect an expected increase in utilization of 4.0 percent among persons currently covered under HMOs;

? Prescription Drug Rebate – We assume that the program would receive the same percentage rebates from drug manufacturers currently received under the current Medicaid program, which was 17.9 percent in 2000. This compares with an estimated average rebate of 8.3 percent for private insurers.

## Table 4
## Analysis of Program Costs and Revenues under the Vermont Single-Payer Proposal in 2001 (in millions)

| Uses of Funds | | Sources of Funds | | |
|---|---|---|---|---|
| **Program Expenditures** | | **Inter-Governmental Transfer Revenues** | | |
| **Benefit Payments** [a/] | **$1,705.5** | **CHAMPUS/Military** [e/] | | **$53.8** |
| **Payment Adjustments** [b/] | **($124.5)** | **Medicare** [f/] | | **$363.8** |
| Uncompensated Care Savings | ($50.0) | **Medicaid** | | **$216.5** |
| Provider Administration | ($47.1) | State Share g/ | | $82.3 |
| Managed Care Adjustment | $2.8 | Federal Share h/ | | $134.2 |
| Prescription Drug Rebate | ($30.2) | **Other State** [i/] | | $0.7 |
| **State and Local Employee Benefits** [c/] | ($59.4) | **Federal Employee Health Benefits Program** | | $10.1 |
| **Insurance Administration** [d/] | $35.8 | **TOTAL Government Transfers** | | **$644.9** |
| | | **New Tax Revenues** | | |
| | | **Payroll Tax (Net of Wage Effect)** [j/] | | $920.2 |
| | | Employer (5.8%) | $613.2 | |
| | | Employee (2.9%) | $307.0 | |
| | | **Wage Effects of Payroll Tax** [k/] | | ($7.7) |
| | | **TOTAL Tax Revenues** | | **$912.5** |
| **TOTAL Expenses** | **$1,557.4** | **TOTAL Revenues** | | **$1,557.4** |

a/ Includes provider payments for acute care health services that are covered under the program. Provider payments are estimated based upon overall average provider payment levels under current programs. Excludes patient copayments and spending for non-covered services.

b/ We assume that provider payment rates are reduced to reflect reduced uncompensated care expenses and savings in provider administrative costs.

c/ Reflects the net change in state and local employee benefits expenditures as a result of shifting from employer-based health coverage to the payroll tax.

d/ Includes the cost of administering benefits under the single-payer program. Estimates based upon the cost of administering benefits under the Medicare program.

e/ The program will be reimbursed for services provided to persons who are covered under the CHAMPUS program.

f/ Federal Medicare program funding for Vermont residents would be transferred to the Vermont single-payer program. This includes federal funding for Part-A and the federal share of funding for Part-B.

g/ The state share of funding for the Medicaid program is transferred to the single-payer program. Estimates exclude the state share of funding for disproportionate share hospital payments.

h/ The federal share of funding for the Medicaid acute care program would be transferred to the single-payer program. Includes benefits payments, administration and the federal share of disproportionate share hospital payments.

i/ Current state and local funding for mental health and various indigent care programs would be transferred to the single-payer program. Includes funding only for state health programs, which are not also included under the state share of the Medicaid program.

j/ The program imposes a payroll tax on employers of 5.8 percent and employees of 2.9 percent.

k/ Employers are assumed to pass-on the change in employer health care costs under the program as a change in wages resulting in corresponding changes in state personal income tax revenues.

Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

Total benefit payments after adjustments would be $1,581.0 million. Also, the payroll tax for state and local workers would be less than the cost of their current coverage. Consequently, the state and local governments would save about $59.4 million under the program in the cost of providing coverage to state and local workers. Total administrative costs would be $35.8 million, which is equal to about 2.1 percent of benefit payments.

### *2. Inter-Governmental Transfer Revenues*

The program would receive funds that otherwise would have been used to fund health care benefits for Vermont residents. Specifically, funds from Medicaid, Medicare, and various state and local health programs would be used to cover program costs. Total funding from these sources would be $644.9 million in 2001. These funds include:

? ***Medicare Funds*** -- Federal Medicare program funding for Vermont residents would be transferred to the Vermont single-payer program. This includes federal funding for Part-A and the federal share of funding for Part-B (Medicare beneficiaries would continue to pay the Medicare Part-B premium);

? ***Federal Share of Medicaid Funds*** – The federal share of funding for the Medicaid program would be transferred to the single-payer program. Includes amounts for benefits payments, administration and the federal share of disproportionate share hospital (DSH) payments;

? ***State Share of Medicaid Funds*** – The state share of funding for the Medicaid program is transferred to the single-payer program;

? ***Other State Funds*** – Current state funding for mental health would be transferred to the single-payer program; and

? ***CHAMPUS/Military*** – Funding for services provided to Vermont residents covered under the CHAMPUS program would be used to fund the program.

### *3. Tax Revenues*

The remainder of the program would be financed with new taxes created specifically for the program. In addition, there would be changes in personal income tax revenues as wage levels adjust in response to the payroll tax imposed on employers under the program. Total net tax revenues would be about $912.5 million in 2001. These tax revenues include:

? ***Payroll Tax*** – The program imposes a payroll tax on employers and employees in Vermont. The tax rates in the first year of the program would be 8.7 percent with 5.8 percent paid by employers and 2.9 percent paid by employees;

? ***Wage Effects of Payroll Tax*** – Employers are assumed to pass-on the change in employer health care costs under the program as a change in wages resulting in corresponding changes

in state personal income tax revenues. The payroll tax rate under the program would be adjusted to compensate for this expected revenue loss.

The payroll tax required to fully fund the program would increase steadily over time. The reason for this is that health expenditures are growing faster than wages. Thus, health spending will absorb an increasing share of the state's income. As discussed above, we estimate that under current trends, the payroll tax rate required to fully fund the program would increase from about 8.7 percent in 2001 to 10.3 percent by 2010.

## B. Federal Health Spending in Vermont

Under the single-payer plan, all federal funding for health benefits provided to Vermont residents would be transferred to the single-payer program. This includes funding for Medicare, Medicaid and the CHAMPUS/Military programs. Thus, the transfer of funding to the single-payer plan would have no net impact on federal expenditures.

Under the assumed tax rates, we estimated that there would still be a net cost to the federal government of about $34.3 million in 2001 (***Table 5***). This reflects a loss of federal income tax revenues as employers adjust wage levels in response to the payroll tax.

**Table 5**
**Change in Federal Health Spending in Vermont under the Single Payer Proposal in 2001 (in millions)**

| | | |
|---|---|---|
| **Federal Employee Health Benefit** [a/] | | $10.1 |
| **Spending in Current Programs** [b/] | | ($551.8) |
| Medicare Benefits | ($363.8) | |
| Medicaid | ($134.2) | |
| CHAMPUS/VA | ($53.8) | |
| **Transfers to State Program** [c/] | | $561.9 |
| **Federal Income and FICA Tax Loss** [d/] | | $34.3 |
| **Net Cost to Federal Government** | | |
| **Net Cost to Federal Government** | | **$34.3** |

a/ Includes reduction in costs for benefits to federal employees and retirees offset by the payroll tax.
b/ Benefits for Medicare recipients, Medicaid beneficiaries, and CHAMPUS/VA beneficiaries will be eliminated as those beneficiaries are enrolled in to the single-payer plan.
c/ The federal government will transfer to the state their share of savings to current federal programs.
d/ Tax loss due to reduced wage levels resulting from higher employer costs.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

## VI. EMPLOYER HEALTH SPENDING

Private employers would be one of the primary sources of financing under a single-payer plan through payroll tax payments. Current employer health benefits obligations would be replaced with a tax computed as a percentage of employee payroll. The net impact of this shift to a payroll tax for individual employers would vary depending upon the degree to which individual employers currently offer insurance, employee wage levels and whether they provide coverage for retirees. The impact of the single-payer program on employer health spending is discussed in the following sections:

? Impact on Employer Spending by Size of Firm and Industry;

? Distributional Impacts on Employers; and

? Wage Effects.

### A. Impact on Total Private Employer Spending

The impact of the single-payer plan on employer health spending will differ for workers and retirees. Private employers will spend about $373.8 million on coverage for workers and dependents under current trends in 2001 (***Table 6***). Under a single-payer plan employers no longer pay this cost, but instead pay a tax equal to 5.8 percent of payroll, which would be equal to about $520.2 million in 2001. Of this $520.2 million in tax payments, about $119.6 million would be paid by firms that currently do not provide coverage.

Our analysis indicates that employer costs associated with retirees would decline substantially under the program. This is because many of the services covered by these plans for retirees would become covered under the single-payer program. Overall, employers would save about $30.1 million on retiree benefits under the program.

The impact of a single-payer plan will differ for firms that now offer insurance and those that do not insure. Overall, firms that currently offer insurance actually would see a relatively small increase in health care spending of about $3.6 million in 2001, primarily due to savings in retiree benefit payments. Firms not now insuring would pay $119.6 million in payroll taxes under the program.

**Table 6**
**The Impact of the Single Payer Proposal on Private Employer Health Spending for workers in Vermont in 2001: Before Wage Effects (in millions)**

| | Firms that Now Offer Insurance | Firms That Do Not Now Offer Insurance | All Firms |
|---|---|---|---|
| **Spending Under Current Policy** | | | |
| **Workers and Dependents** | $373.8 | - - - | $373.8 |
| **Retirees** | $32.4 | - - - | $32.4 |
| **Current Spending** | **$406.2** | **- - -** | **$406.2** |
| **Spending Under Reform** | | | |
| **Wrap-Around Coverage** | | | |
| Workers and Dependents [a/] | $6.9 | - - - | $650.3 |
| Retiree Premiums | $2.3 | - - - | $14.2 |
| **Payroll Tax** [b/] | $400.6 | $119.6 | $520.2 |
| **TOTAL** | **$409.8** | **$119.6** | **$529.4** |
| **Change in Employer Costs** | | | |
| **Net Change** | **$3.6** | **$119.6** | **$123.2** |

a/ Employers in Vermont will no longer provide primary coverage for workers, dependents, and retirees.
b/ Employers are required to pay a payroll tax to fund the single payer program.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

## B. Impact on Employer Health Spending by Size of Firm and Industry

Overall, health spending for private employers would increase by 30 percent under the single-payer model. We estimate that employer health spending for the smallest firms (those with less than 10 employees) would increase by 97 percent under the single-payer program ***(Table 7)***. By comparison, firms with 1,000 or more workers would actually see a decline in health spending of 1.4 percent. This reflects the fact that larger employers are more likely to offer retiree coverage. The analysis of changes in health spending by industry indicates that only the finance and transportation sectors would see a net decrease in costs. ***Table 8*** shows the change in health spending per worker by industry and firm size.

Average employer payroll tax payments would equal about $1,452 for firms that do not now offer insurance ***(Figure 5)***. By contrast, firms that currently offer coverage would see an average increase of $20 per worker. These savings are not uniform across employers, however. For example, employers with between 100 and 499 workers who currently offer coverage would see an increase in costs averaging $466 per worker.

**Table 7**
**Private Employer Health Spending in Vermont under Current Policy and under the Single Payer Proposal by Firm Size and Industry in 2001: Before Wage Effects**

| | Spending under Current Policy (in millions) a/ | Total Spending under the Single-Payer Plan (millions) b/ | Percent Increase (Decrease) |
|---|---|---|---|
| **Firm Size** | | | |
| **Under 10** | $61.6 | $121.3 | 96.9% |
| **10 - 24** | $41.0 | $52.5 | 28.1% |
| **25 - 99** | $42.0 | $69.8 | 66.2% |
| **100 - 499** | $71.6 | $98.6 | 37.7% |
| **500 - 999** | $31.4 | $30.9 | (1.6%) |
| **1,000 or More** | $158.5 | $156.3 | (1.4%) |
| **Industry** | | | |
| **Construction** | $20.4 | $33.7 | 65.2% |
| **Manufacturing** | $113.0 | $125.6 | 11.2% |
| **Transportation** | $39.7 | $33.8 | (14.9%) |
| **Wholesale Trade** | $15.2 | $20.9 | 37.5% |
| **Retail Trade** | $44.3 | $66.4 | 50.0% |
| **Services** | $137.9 | $217.6 | 57.8% |
| **Finance** | $35.7 | $31.6 | (11.5%) |
| **All Private Firms** | **$406.2** | **$520.2** | **28.1%** |

a/ Includes the employer contributions for benefits for workers, dependents and retirees.
b/ Includes payroll tax payments and the cost of continuing wrap around benefits for workers, dependents and retirees.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

## C. Wage Effects

Empirical evidence indicates that employers are likely to pass on much of the increase in employer costs to employees in the form of reduced wages or lost jobs.[7] Employers are typically limited in what they can charge in the market place necessitating changes in other compensation costs as employer payroll taxes are imposed. The economic literature indicates that much of the cost of increased health care spending has historically been passed on to workers.[8]

[7] See, for example, Jonathan Gruber and Alan B. Kreuger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance," in Tax Policy and the Economy (1991); Jonathan Gruber, "The Incidence of Mandated Maternity Benefits, " American Economic Review, (forthcoming); and Lawrence H. Summers, "Some Simple Economics of Mandated Benefits, " American Economic Review (May 1989).

[8] See, for example, James Heckman, "What Has Been Learned About Labor Supply in the Past Twenty years?" American Economic Review, (May 1993).

## Table 8
## Impact of a Single Payer Program on Private Employers in Vermont by Firm Size and Industry in 2001: Before Wage Effects

| | Total Change in Health Spending (millions) | | | Change in Health Spending Per Worker | | |
|---|---|---|---|---|---|---|
| | Firms that Now Offer Insurance | Firms That Do Not Now Offer Insurance | All firms | Firms that Now Offer Insurance | Firms That Do Not Now Offer Insurance | All firms |
| **Firm Size** | | | | | | |
| **Under 10** | ($18.7) | $78.4 | $59.7 | ($997) | $1,515 | $846 |
| **10 - 24** | ($3.8) | $15.3 | $11.5 | ($226) | $1,427 | $418 |
| **25 - 99** | $18.7 | $9.1 | $27.8 | $674 | $1,348 | $807 |
| **100 - 499** | $17.5 | $9.5 | $27.0 | $466 | $1,372 | $606 |
| **500 - 999** | ($2.2) | $1.7 | ($0.5) | ($194) | $1,092 | ($38) |
| **1,000 or More** | ($7.8) | $5.6 | ($2.2) | ($125) | $1,210 | ($33) |
| **Industry** | | | | | | |
| **Construction** | ($1.8) | $15.1 | $13.3 | ($244) | $2,106 | $921 |
| **Manufacturing** | $3.6 | $9.0 | $12.6 | $77 | $1,681 | $242 |
| **Transportation** | ($8.8) | $2.8 | ($5.9) | ($831) | $1,350 | ($469) |
| **Wholesale Trade** | $2.9 | $2.8 | $5.7 | $391 | $1,412 | $611 |
| **Retail Trade** | $2.5 | $19.6 | $22.1 | $93 | $943 | $460 |
| **Services** | $14.4 | $65.3 | $79.7 | $222 | $1,537 | $744 |
| **Finance** | ($9.2) | $5.1 | ($4.1) | ($825) | $1,958 | ($300) |
| **All Private Firms** | **$3.6** | **$119.6** | **$123.2** | **$20** | **$1,452** | **$479** |

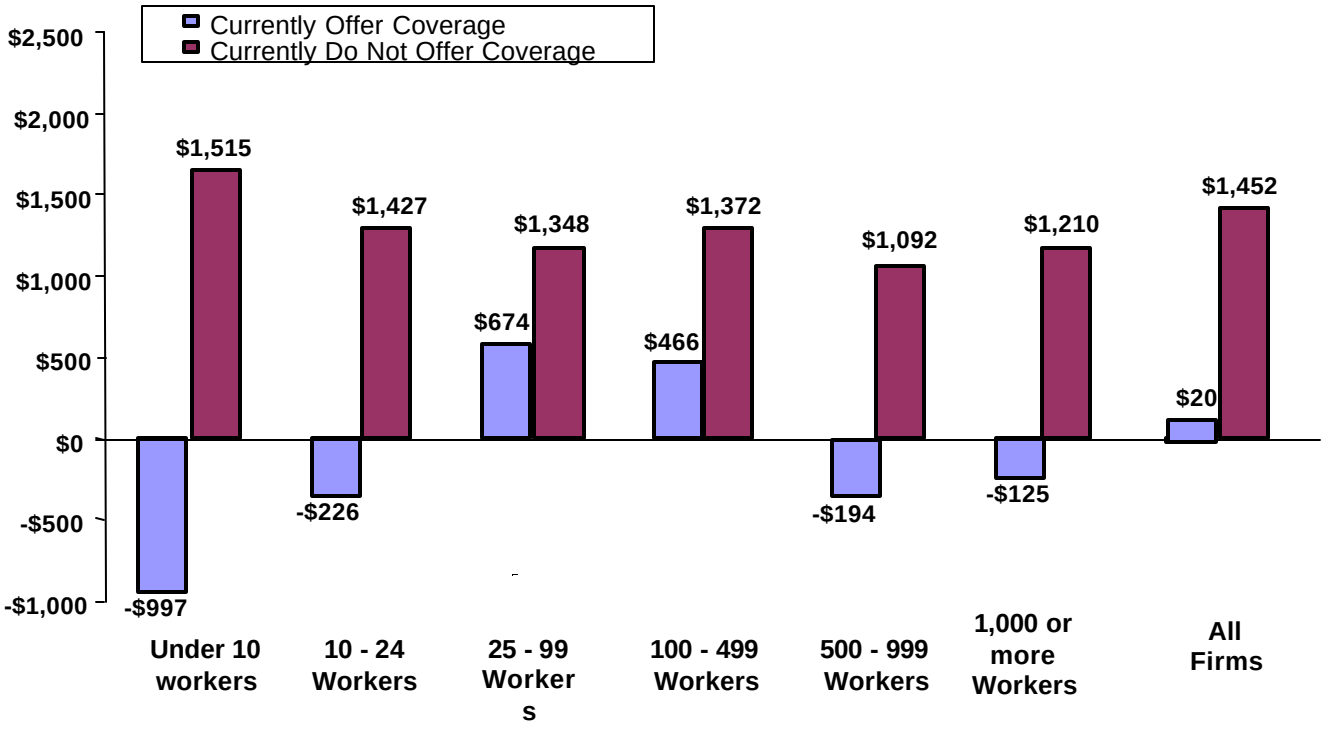
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

Based upon a review of the literature, we assume that 88 percent of the change in employer's cost due to the payroll tax will result in changes in wages to the employee.[9] Conversely, in firms that see net savings under the singe-payer plan most of these savings are likely to result in wage increases as labor markets force adjustments to overall employee compensation packages in response to these changes in employer health benefits costs. We estimate a net reduction in wages of $134.9 million under the single-payer program for Vermont.

[9] This estimate is consistent with estimate found in the literature. For example, Gruber and Kreuger, op. cit., find that about 85 percent of the costs of mandated worker's compensation benefits are shifted to employees in the form of reduced wages, while Gruber, op. cit., found that virtually all of the employer's cost of mandated maternity benefits are shifted to the employee.

## Figure 5

### Change in Private Employer Health Spending Per Worker by Firm Size and Current Insuring Status: Before Wage Effects




| Percent of Workers by Firm Size | | | | | | |
|---|---|---|---|---|---|---|
| 27.4% | 10.7% | 13.4% | 17.3% | 5.1% | 26.1% | 100.0% |

a/ Insufficient Data.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

## VII. HOUSEHOLD HEALTH SPENDING

Under a single-payer program, Vermont residents would no longer pay health insurance premiums and would face only minimal copayments for health services. Instead, households would pay taxes on earnings. In addition, household incomes would be affected by wage adjustments resulting from increased employer payroll taxes. These changes in the way in which care is financed would substantially alter the distribution of health care costs across households of various age and income groups.

Our estimates of the impact on household health spending are presented in the following sections:

? Impact on Total Household Health Spending;

? Impact on Average Household Health Spending;

? Distributional Impact on Households; and

? Impact on Households by Current Insurance Status.

### A. Impact on Total Household Health Spending

We estimate that household health spending would decline by $122.3 million under the single-payer program (***Table 9***). This includes the elimination of household premium payments for private health insurance ($321.8 million); and reduced household out-of-pocket payments for health services ($218.8 million). These savings would be offset by increased tax payments of $307 million. In addition, we estimate a loss of wages to households (after tax offsets) of about $111.3 million as employers pass on the increased cost of complying with the payroll tax to workers in the form of reduced wages. The factors affecting household spending include:

? ***Premium Reductions*** – Because a single-payer plan would eliminate premium payments for services covered under the program, we estimate a reduction in private insurance premiums of about $321.8 million;[10]

? ***Reduced Out-of-Pocket Spending*** – Household out-of-pocket spending for health care would be reduced under a single-payer plan because (1) there is little cost-sharing required (i.e., a $10.00 copayment), and (2) the program provides a comprehensive benefits package that would provide comprehensive coverage for services often excluded under existing plans. The reduction in out-of-pocket spending would be $218.8 million;

[10] Many persons with employer sponsored coverage for services not covered under the single-payer program may still be required by the employer to make premium contributions for this supplemental coverage.

**Table 9**
**Impact of the Single Payer Proposal on Households in Vermont in 2001**
**(in millions)**

| | Without Wage Effects | With Wage Effects |
|---|---|---|
| **Premium Payments** | | |
| Premium Reductions | ($321.8) | ($321.8) |
| **Direct Payments for Care** | | |
| Reduced Out-of-Pocket Spending for Acute Care [a/] | ($218.8) | ($218.8) |
| **Tax Payments** | | |
| Dedicated Program Tax Payments | $307.0 | $307.0 |
| **After-Tax Wage Effects** | | |
| After-Tax Wage Effects [b/] | N/A | $111.3 |
| **Net Change in Household Spending** | | |
| Net Impact on Household Spending | ($233.6) | ($122.3) |

a/ Family out-of-pocket payments for acute care health services will be reduced under the program due to: 1) reduced patient cost-sharing requirements under the plan and 2) expanded coverage for services often excluded under existing plans.

b/ Employers are assumed to pass-on the cost (savings) resulting from shifting from employer-based insurance to the payroll tax in the form of changes in wages.

Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

? ***New Tax Payments*** – Vermont residents would pay the employee share of the payroll tax (i.e., 2.9 percent);

? ***Wage Effects*** – As described in the previous section on employer health spending, we estimate that about 88 percent of increased employer costs would be passed-on to employees in the form of reduced wages.

## B. Impact on Average Household Health Spending

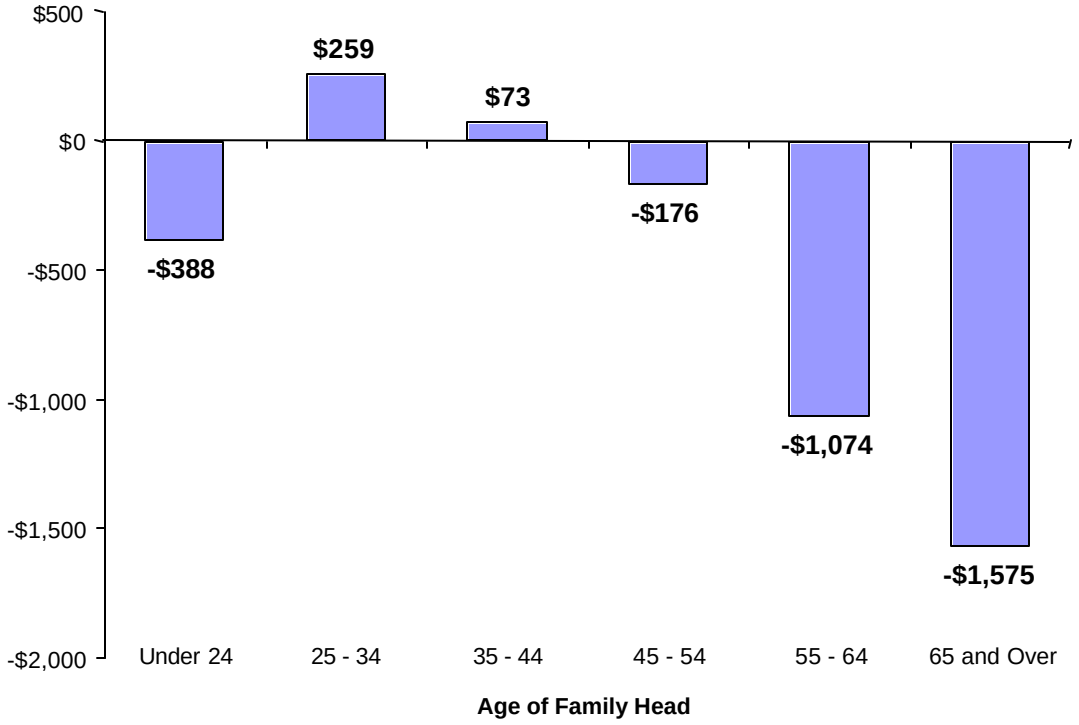
Overall, we estimate that households would see health spending decrease by an average of about $441 per family under the single-payer model in 2001 ***(Table 10).*** Savings under a single-payer plan would tend to be greatest for older individuals. For example, families headed by an individual age 65 or older would save about $1,575 per family ***(Figure 6)***. By contrast, average health spending would increase by up to $259 per family for younger age groups. On average, household savings would be greatest for individuals facing high out-of-pocket costs under current policy (***Table 11)***.

## Table 10
## Change in Average Family Spending on Health Care in Vermont Under the Single-Payer Proposal in 2001 by Family Income and Age of Householder: After Wage Effects [a/ b/]

| | Average Change by Age of Householder | | |
|---|---|---|---|
| **Family Income** | **Under Age 65** | **Age 65 and Older** | **All Families** |
| **Less than $10,000** | ($450) | ($1,006) | ($608) |
| **$10,000 - $14,999** | ($296) | ($1,396) | ($721) |
| **$15,000 - $19,999** | ($543) | ($1,961) | ($1,000) |
| **$20,000 - $29,999** | ($837) | ($1,567) | ($1,038) |
| **$30,000 - $39,999** | ($1,001) | ($2,482) | ($1,238) |
| **$40,000 - $49,999** | ($1,232) | ($2,351) | ($1,397) |
| **$50,000 - $74,999** | ($853) | ($2,081) | ($995) |
| **$75,000 - $99,999** | $229 | ($1,928) | $58 |
| **$100,000 - $149,999** | $1,191 | ($1,732) | $933 |
| **$150,000 or More** | $4,861 | $(357) | $4,490 |
| **All Families** | **($171)** | **($1,575)** | **($441)** |

a/ Excludes institutionalized persons.
b/ Includes changes in premiums, out-of-pocket expenses, taxes earmarked to fund health reform, and after tax wage effects.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

## Figure 6
## Change in Average Family Health Spending by Age of Family Head Under the Vermont Single-Payer Program in 2001: After Wage Effects




Source: Lewin Group Estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

## Table 11
## Change in Average Household Spending on Health Care in Vermont Under the Single-Payer Proposal in 2001: After Wage Effects [a/]

| | Number of Families (thousands) | Average Household Spending Under Current Policy | Change in Spending Under Single-Payer Plan [b/] |
|---|---|---|---|
| **Age of Head** | | | |
| **Under 24** | 22.8 | $1,254 | ($388) |
| **25 - 34** | 47.8 | $1,873 | $259 |
| **34 - 44** | 63.2 | $2,374 | $73 |
| **45 - 54** | 55.9 | $3,100 | ($176) |
| **55 - 64** | 34.1 | $3,084 | ($1,074) |
| **65 and Over** | 53.1 | $3,512 | ($1,575) |
| **Marital Status** | | | |
| **Married** | 132.1 | $3,560 | ($521) |
| **Single** | 144.8 | $1,815 | ($721) |
| **Male** | 47.3 | $1,281 | $187 |
| **Female** | 97.5 | $2,074 | ($632) |
| **Income** | | | |
| **Less than $10,000** | 32.0 | $1,056 | ($608) |
| **$10,000 - $14,999** | 23.7 | $1,791 | ($721) |
| **$15,000 - $19,999** | 19.9 | $1,941 | ($1,000) |
| **$20,000 - $29,999** | 33.4 | $2,207 | ($1,038) |
| **$30,000 - $39,999** | 33.7 | $2,881 | ($1,238) |
| **$40,000 - $49,999** | 24.5 | $2,758 | ($1,397) |
| **$50,000 - $74,999** | 47.5 | $3,370 | ($995) |
| **$75,000 - $99,999** | 27.9 | $3,232 | $58 |
| **$100,000 - $149,999** | 19.6 | $3,549 | $993 |
| **$150,000 or More** | 14.8 | $4,083 | $4,490 |
| **Income as a Percentage of the Federal Poverty Level (FPL)** | | | |
| **Below FPL** | 32.5 | $991 | ($525) |
| **100% - 149%** | 25.0 | $2,093 | ($1,091) |
| **150% - 199%** | 69.1 | $2,459 | ($1,160) |
| **200% - 249%** | 40.2 | $3,257 | ($1,360) |
| **250% - 299%** | 31.1 | $3,072 | ($999) |
| **300% or More** | 78.9 | $3,193 | $1,123 |
| **Current Out-of-Pocket Costs [c/]** | | | |
| **Less than $500** | 90.1 | $325 | $664 |
| **$500 - $999** | 71.5 | $1,682 | $314 |
| **$1,000 - $2,499** | 68.9 | $3,443 | ($828) |
| **$2,500 - $4,999** | 40.7 | $6,752 | ($2,727) |
| **$5,000 - $9,999** | 5.1 | $11,874 | ($5,644) |
| **$10,000 or More** | 0.4 | $25,038 | ($16,753) |
| **TOTAL** | **276.8** | **$2,648** | **($441)** |

a/ Excludes institutionalized persons.

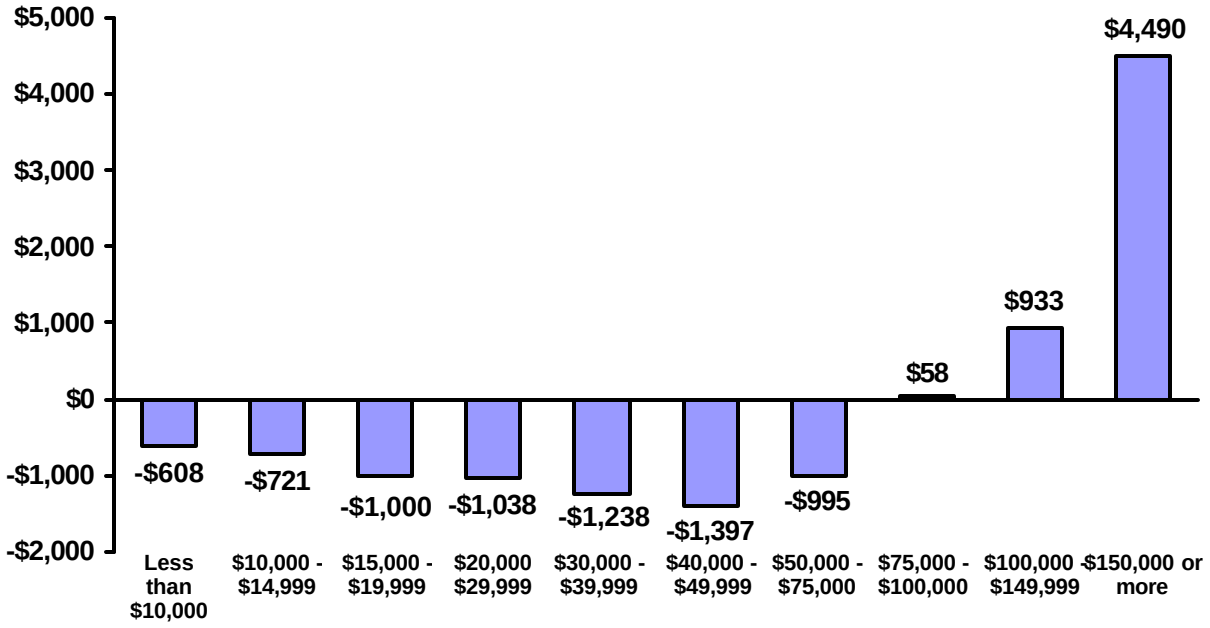
b/ Includes changes in premiums, out-of-pocket expenses, taxes earmarked to fund health reform and after-tax wage effects.

c/ Out of pocket costs include direct payments for care and exclude family premium payments.

Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

In general, the single-payer plan would tend to reduce health care costs for lower- and middle-income families. For example, families with under $75,000 in annual income would, on average, see savings. However, health spending for families with $150,000 or more in income would increase by about $4,490 per family ***(Figure 7)***. This reflects the fact that the bill shifts Vermont residents from a premium financed system. Where premium payments generally do not vary with income to a tax financed system where total health spending would be in proportion to family earnings. ***Table 10*** shows the change in average family health spending by age and income.

**Figure 7**
**Change in Average Family Health Spending Per Family Under the Vermont Single-Payer Program in 2001: After Wage Effects**




Source: Lewin Group Estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

## C. Distributional Impacts

The net impact of a single-payer program on individual households would vary depending upon their current level of health spending, the extent to which they now have health coverage and their income. In general, households with little or no health coverage and/or high out-of-pocket costs will tend to benefit under the plan. Conversely, many persons who now have comprehensive coverage would pay more as Vermont shifts to a tax financed system. Moreover, by shifting to an income related tax to finance health care, higher income persons would tend to pay more while lower income persons would tend to pay less. Thus, there would be extensive variability in the net impact on households.

About half of all families in Vermont would see a net decrease in family health spending of $20 or more while most of the remaining families would see an increase of $20 or more ***(Table 12)***. Only about 1.3 percent of families would see a net change in spending of less than $20.

## Table 12
## Distribution of Families in Vermont by Change in Household Spending under the Single-Payer Proposal in 2001: After Wage Effects [a/]

| | | Increase in Family Health Costs | | | | | Change of Less than $20 | Reduction in Family Health Costs | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Family Income** | **All Families (thousands)** | **$1,000 or More** | **$500 - $999** | **$250 - $499** | **$100 - $249** | **$20 - $99** | | **$20 - $99** | **$100 - $249** | **$250 - $499** | **$500 - $999** | **$1,000 or More** |
| **Family Income** | | | | | | | | | | | | |
| **Less than $10,000** | 32.0 | 7.0 | 11.9 | 14.1 | 14.0 | 7.1 | 4.1 | 1.9 | 1.6 | 5.4 | 6.2 | 26.6 |
| **$10,000 - $14,999** | 23.7 | 16.8 | 6.7 | 6.6 | 4.0 | 3.6 | 2.5 | 0.6 | 2.3 | 5.0 | 17.1 | 34.8 |
| **$15,000 - $19,999** | 19.0 | 17.9 | 8.0 | 6.1 | 4.1 | 3.4 | 1.7 | 1.3 | 3.0 | 3.8 | 7.9 | 42.8 |
| **$20,000 - $29,999** | 33.4 | 13.3 | 11.5 | 4.8 | 4.3 | 1.5 | 0.9 | 1.4 | 1.8 | 4.3 | 10.7 | 45.6 |
| **$30,000 - $39,999** | 33.7 | 17.7 | 10.8 | 7.4 | 3.3 | 0.9 | 0.8 | 1.1 | 2.7 | 3.3 | 5.1 | 46.9 |
| **$40,000 - $49,999** | 24.5 | 19.1 | 8.6 | 4.1 | 1.8 | 1.1 | 1.2 | 1.7 | 1.8 | 2.2 | 6.4 | 52.0 |
| **$50,000 - $74,999** | 47.5 | 27.1 | 5.6 | 3.3 | 1.4 | 0.4 | 0.8 | 1.3 | 1.6 | 2.3 | 5.6 | 50.5 |
| **$75,000 - $99,999** | 27.9 | 44.1 | 5.6 | 2.1 | 2.0 | 1.0 | 0.1 | 0.7 | 2.2 | 3.3 | 5.7 | 33.3 |
| **$100,000 – 149,999** | 19.6 | 55.1 | 5.6 | 2.9 | 1.4 | 0.8 | 0.1 | 1.6 | 0.5 | 2.9 | 3.1 | 26.0 |
| **$150,000 or More** | 14.7 | 78.8 | 2.1 | 1.1 | 1.4 | 0.7 | 0.0 | 0.2 | 0.2 | 1.8 | 1.5 | 12.3 |
| **Age of Family Head** | | | | | | | | | | | | |
| **Head Under Age 65** | 223.7 | 30.9 | 9.1 | 6.0 | 3.9 | 2.1 | 1.1 | 0.9 | 1.9 | 3.3 | 6.3 | 34.4 |
| **Head Age 65 or Older** | 53.1 | 6.0 | 3.5 | 3.5 | 3.9 | 1.6 | 2.1 | 2.5 | 1.6 | 4.0 | 10.3 | 60.9 |
| **TOTAL** | **276.8** | **26.2** | **8.0** | **5.5** | **3.9** | **2.0** | **1.3** | **1.2** | **1.8** | **3.5** | **7.0** | **39.5** |

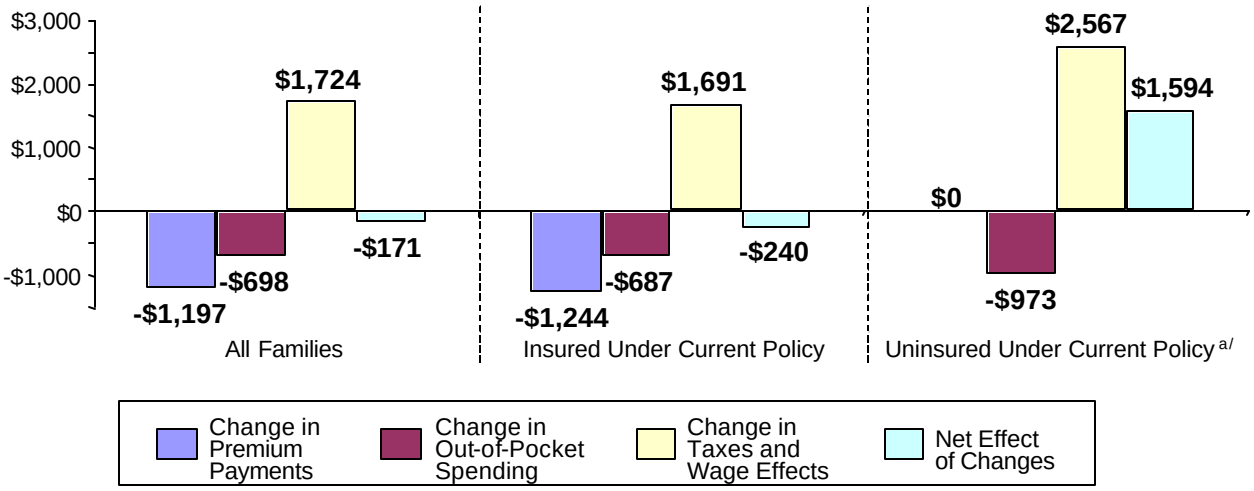
a/ Includes changes in premiums, out-of-pocket expenses, taxes earmarked to fund health reform and after-tax wage effects. Excludes institutionalized persons.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

About 26.2 percent of households would see a net increase in health spending of $1,000 or more while about 39.5 percent would see a net reduction in spending of $1,000 or more. Families at the lower and middle income levels would tend to have the greatest savings. For example, up to 52 percent of families with incomes of less than $50,000 would see savings of $1,000 or more. By contrast, families in the highest income groups would tend to see the largest increases in health spending. For example, about 79 percent of families with incomes of $150,000 or more would see an increase in health-related costs of $1,000 or more.

## D. Impact on Households by Current Insurance Status

The effects of a single-payer program would vary between currently insured and currently uninsured households. This is because the currently uninsured pay no premiums and would therefore see no premium savings. For non-aged households in 2001, we estimate health spending would decrease by about $240 for the currently insured individuals and families while increasing spending by about $1,594 per family for the currently uninsured population (***Figure 8***).

**Figure 8**
**Change in Health Spending for Families Headed by an Individual Under Age 65 in Vermont by Current Insured Status in 2001**




a/ Includes uninsured single individuals and families with one or more uninsured members.

The net increase in spending for the uninsured reflects the fact that a disproportionate share of uninsured persons are young and comparatively healthy. Consequently, the taxes paid by these individuals tend to be greater than the amounts of out-of-pocket health spending that would become covered under the program for these individuals. This would result in a net increase in spending for those who would have been uninsured in the absence of the program.

# Appendix A

# Data and Methods Used in Analysis of the Single-Payer Program for Vermont

## Data and Assumptions

The Lewin Group developed a model of health spending in Vermont to be used to simulate the impact of alternative health reform proposals including the single-payer model. This model is designed to estimate the potential impacts of alternating health reform proposals on insurance coverage and health expenditures in Vermont over the 2001 through 2010 period. Estimates of the net impact of these reform options on costs and coverage are determined by comparing estimates under the single-payer plan to our estimates of spending under current trends. The model presents estimates of total program costs, net changes in total state health spending, changes in spending by type of service, and changes in administrative costs.

The model is based upon Lewin Group's "best assumptions on the impact of a single-payer program on health spending in Vermont. The model provides outputs that show the impact of the single-payer program on health care expenditures by type of service and type of spending. It also shows changes in spending for employers by type of firm and for households in various income groups.

## A. Baseline Projections

The baseline in this analysis is a projection of the amount of health spending by type of service for each year between 2001 and 2010 under the existing health care system in Vermont. The Lewin Group first used estimates of health expenditures for Vermont residents in 1998 [11]. We then inflated these cost estimates to future years based upon estimates of the rate of growth in health spending developed by the Health Care Financing Administration (HCFA) by type of service and source of payment. The inflation rates were adjusted to account for the difference in historical health spending growth in Vermont compared to national spending growth.

Estimates of health spending by type of service and source of payment are based upon estimates provided by the Vermont Division of Health Care Administration. These estimates of Vermont health spending by type of service and source of payment in 2001 are presented above in **Figure 2.**

***Table A-1*** presents our estimates of the growth in real per-capita health spending annually for Vermont from 1999 through 2010.

[11] Vermont Division of Health Care Administration, "Vermont Health Care Expenditure Analysis, 1998".

**Table A-1**
**Baseline Real Growth In Per Capita Health Care Expenditures in Vermont**

| | Average Annual Real Rate of Growth in Per Capita Health Spending |
|---|---|
| **1999** | 3.7 |
| **2000** | 4.8 |
| **2001** | 4.9 |
| **2002** | 4.8 |
| **2003** | 4.1 |
| **2004** | 3.7 |
| **2005** | 3.2 |
| **2006** | 2.9 |
| **2007** | 2.3 |
| **2008** | 2.4 |
| **2009** | 2.1 |
| **2010** | 2.5 |

a/ Based upon HCFA projected growth rates nationwide.
Source: Lewin Group estimates.

## B. Single-payer Assumptions

Under the single-payer program, all Vermont residents would be covered under a single government-financed insurance program. The benefits package would cover nearly all health care costs except cosmetic surgery, non-prescription drugs, private hospital rooms and orthodontia. The plan would require $10 copayments for health services but would not require a deductible.

Hospitals would be placed on annual budgets, which limit the rate of growth in hospital costs. Spending for other services also would be controlled through global budgets on health spending that cap health expenditure growth at a predetermined level. We assume that there will be no HMOs in the program. However, the program would use a primary care referral model (i.e., gatekeeper model) which could help limit the use of specialists.

The single-payer model would have several impacts on statewide health spending. For example, there would be an increase in health services utilization as persons who are uninsured or under insured under the current system become covered. Utilization is also likely to increase due to the fact that HMOs will not be used in the program. However, these increases in costs would be largely offset by reductions in administrative costs for insurers and providers. Costs will also fall over-time due to the use of health spending budgets, which reduce the rate of growth in health spending.

***Figure A-1*** presents our assumptions on the cost impacts of the various factors affecting utilization and expenditures under a single-payer system. These are based upon prior Lewin Group analyses of the impacts of converting from the current system to a single-payer system.[12] These assumptions include:

## Insurer Administration

? **Single-Payer Administrative Costs as a Percentage of Benefits:** We estimated administrative costs under a Vermont single-payer system by extrapolating from the administrative costs for the US Medicare program after adjusting for key differences between the Medicare program and the single-payer model for Vermont, including the elimination of hospital claims filing (hospital claims are eliminated under the single-payer by placing hospitals on annual budgets). Based upon these assumptions, we estimate that administrative costs under the Vermont single-payer program will equal about 2.1 percent of claims.

## Provider Administration

? **Hospital Administrative Cost Savings:** We estimate that currently, hospitals spend 34.2 percent of net revenues on administration, which includes all labor and overhead expenditures attributed to functions other than those directly related to patient care, such as accounting, credit and collections, and admitting. The single-payer proposal would all but eliminate hospital administrative costs associated with filing claims because under the this model, hospitals are given an annual operating budget covering all services provided by the hospital. Based upon our analysis of the hospital data, we estimate that hospital administrative costs would be reduced by about 14 percent in 2001 under the single-payer model: 14 percent of 33.7 percent equals a net saving of 4.7 percent.

? **Physician Administrative Costs Savings:** Based upon Lewin Group analyses of physician practice expenses, we estimate that 32 percent of revenues for all physicians are devoted to administrative functions such as practice management and insurer-related functions (this includes the cost of physician time devoted to administration). Based upon our earlier research on the single-payer system, we estimated that physician administrative costs would be reduced by about 19 percent under the single-payer model: 26 percent of 32 percent equals net savings of 6.1 percent.

[12] Sheils, John F., Young, Gary J., "National Health Spending under a Single-Payer System: The Canadian Approach," Staff Working Paper, The Lewin Group, Inc., January 1992.

## Figure A-1

### Assumptions Concerning the Cost Impacts of a Single-Payer System in Vermont

**Insurer Administrative Costs**

- Single-payer administrative costs as a percentage of benefits: 2.1 percent

**Provider Administrative Costs**

- Hospital administrative costs as a percentage of hospital net revenues: 34.2 percent
- Percentage of hospital administrative costs saved under single-payer model: 14.0 percent
- Net savings: 4.7 percent
- Physician administrative costs as a percentage of physician revenues: 32.0 percent
- Percentage of physician administrative costs saved under single-payer model: 19.0 percent
- Net savings: 6.1 percent

**Utilization for Newly Insured**

- Utilization increase for newly insured and newly covered services for under insured: 69.7 percent

**Increased Utilization For Persons Formerly HMOs**

- Percentage of Vermont residents in HMOs: 3.9 percent
- Percentage increase in utilization: 4.0 percent

**Vermont Rebate Prescription Drug Assumptions**

Single-payer Negotiated Rebate: 17.9 percent

## Newly Insured

? **Increase in Utilization for Newly Insured Persons.** Uninsured persons are expected to increase their utilization of health services once they become insured under the single-payer program. In prior studies, we have estimated the increase in health services utilization for the uninsured population by assuming that utilization for uninsured persons would increase to the levels reported by insured persons with similar age, sex and health status characteristics.[13] Based upon this analysis, we estimate that health services utilization among those who are currently without insurance would increase by 69.7 percent. Utilization of Prescription Drugs, Dental Care and Mental Health Services are assumed to increase in similar proportions for persons who currently are not covered for these services (i. e., the under insured).

## Patient Cost Sharing (Out-of-Pocket Expenses)

? **Change in Utilization Due to Patient Cost Sharing:** The single-payer model would include a $10 copayment requirement which is comparable to what many individuals face in their existing health plans. Consequently, we assume no change in utilization due to cost sharing design.

## Managed Care

? **Utilization Increase Due to Elimination of HMO Capitation Model:** The single-payer system that we are modeling will be a fee-for-service insurance program. There will be no Health Maintenance Organizations (HMOs) in the program. However this single-payer program would feature a primary care referral program (i.e., gatekeeper model) similar to that used in many preferred provider organizations (PPOs) and point-of-service (POS) plans. This would result in increased utilization as the utilization controls under HMOs are lifted. About 3.9 percent of Vermont's residents are now covered under an HMO.[14] Studies have been conducted showing that HMOs reduce utilization by about four percent (much of the savings in HMOs is associated with price discounts).[15] In this analysis, we assume that the elimination of managed care would increase utilization for persons in HMOs to the level observed in PPOs, which translates into a four percent increase in spending for HMO enrollees.

## Prescription Drug Rebate Program

? **Rebate Amount:** We assume that the program will negotiate rebates with prescription drug manufacturers equal to what Vermont now receives under their Medicaid Program, which is about 17.9 percent. By comparison, we estimate that average drug manufacturer rebates are about 8.3 percent for currently insured persons who currently have private coverage.

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[13] "The Financial Impact of *The Health Security Act*," The Lewin Group, Inc., December 9, 1993.

[14] The Interstudy Competitive Edge: HMO Industry Report.

[15] Stapleton, David, "New Evidence on Savings from Managed Care," (A report to the Healthcare Leadership Council), Washington, DC, May 1994.

## C. Global Budgeting Assumptions

Under the single-payer global budgeting system, policymakers set the level of total spending for the State of Vermont. We assume that the budget for spending in the first year of the program (2001) would be equal to the amount that would have been spent in that year under current policy with certain adjustments. For illustrative purposes, we assume that growth in health expenditures over time would be the same as would occur under current trends, adjusted to reflect the changes in utilization and the savings in administration that would occur under the system.

# Appendix G:
# Health Insurance and the Uninsured in Vermont: Policy Option Test Marketing, A Qualitative Study

# Health Insurance and the Uninsured in Vermont:
# Policy Option Test Marketing,
# A Qualitative Study

*September 6, 2001*

**Action Research and**
**The Lewin Group, Inc.**

**Supported by a grant from the Health Resources and Services Administration, U.S. Department of Health and Human Services.**

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## EXECUTIVE SUMMARY

The Office of Vermont Health Access (OVHA) commissioned Action Research to test-market five policy options developed by The Lewin Group and the Steering Committee for the work undertaken as part of the Federal HRSA State Planning Grant. This research was supported by a grant from the Health Resources and Services Administration, U.S. Department of Health and Human Services.

Focus group sessions were conducted with employers and consumers. The qualitative research had one specific goal: to present each of five policy options and obtain feedback from participants. Specifically, the focus groups sought to determine participants' perceptions of the benefits and drawbacks of each plan, to explore questions participants had about each plan and to determine what changes participants would like to see with each plan. The research also sought to rank the plans by participant preference.

### Findings from the Focus Groups

#### *Reactions to Policy Options*

? Generally, most groups found the policy options difficult to digest and understand. Both employers and consumers had many questions about each plan. In most groups, participants indicated at some point that they did not feel that any of the options addressed what they believe are the core issues in insuring more Vermonters: affordable health care and affordable health insurance.

? In nearly every group, participants raised concerns regarding eligibility requirements for participation in the plan. Participants did not like the idea of targeted, or, from their perspective, limited, assistance. Many groups wanted to discuss *"affordable health insurance for all Vermonters."* Whether it was the idea of tax credits for employers who have not been offering insurance or sliding-scale fees available to the uninsured, participants felt that all Vermonters were entitled to relief from the high costs of health care and health insurance.

#### Employer Health Insurance Tax Credits

? This plan was presented as one that would give a refundable tax credit to small employers of low-wage workers who begin offering health insurance to their employees.

? Employers are very attracted to the idea of getting tax relief in exchange for offering health insurance to employees. A number of participants agreed that this policy option would encourage more employers to offer health insurance to employees. Additionally, some employers noted they appreciate that this plan allows employers the freedom to choose which plan they would like to offer.

? Some also noted that they would like to see the amount of the credit increased to 40%-60% of employer costs. Consumers without health insurance suggested that the amount of

reimbursement be tied to a company's profitability, so that the least profitable companies would see the largest proportional reimbursement.

? Employers who are already offering health insurance to employees were upset by the eligibility requirement that would prohibit them from taking advantage of this policy. Participants in other groups also felt this requirement was not fair. Most groups recognize that affordable health insurance is a problem for most small businesses, not just those that do not offer insurance.

? Participants also recognize that, although this policy option would help, many employers cannot afford the cash output required to pay the premiums on a monthly basis. These participants noted that the Employer Health Insurance Tax Credit does not address the need for more affordable health insurance premiums in Vermont. A few also noted that this policy does not address the fact that many low-wage workers cannot afford to pay their share of the premium required to join an employer-sponsored plan.

? Many thought that requiring the firms' average wages to be below the statewide average would be limiting to many businesses. Employers cited the fact that in today's economy, they have had to raise their wages to be competitive. Others noted that their particular industry or location (such as Chittenden County) required them to pay higher-than-average wages and, therefore, they would not be eligible.

## Low-Cost Insurance Plan

? This plan was described as an insurance policy that would cost 15% to 20% less than other commercial plans. The plan would exclude state-mandated benefits and the state would offer a reinsurance program for 90% of benefit payments in excess of $30,000.

? This policy option was widely considered a good plan for those who do not have any other choices. Overall, it was viewed as a moderately adequate solution to the health insurance problem facing employers. Many liked the idea that a low-cost plan would be available; however, contrary to early findings, most felt the excluded benefits were a major drawback to this plan.

? Respondents agreed that in earlier focus groups they championed the idea of being able to purchase a plan free of state-mandated benefits. The difference between what they described earlier and the Low-Cost Insurance Plan was that this plan did not address the deregulation of the insurance industry, which they believed would increase competition and lower prices.

? Some participants indicated that they were not aware that benefits such as home health care and drug and alcohol treatment were state-mandated benefits – and they felt insurance plans should cover those services. Others noted that many people utilize chiropractic and mental health services. Some agreed that the benefits exclusions were an acceptable way to achieve *"cheap"* health insurance coverage; however, most agreed they would not want to be covered by such a plan.

? Many participants agreed that a 15%-20% savings would not be enough to justify purchasing a plan with significantly fewer benefits than other plans. It was noted that a 15%-20% price reduction would barely cover a single year premium increase at the rate that health insurance companies have been raising premium rates.

? Every group was significantly confused by the reinsurance portion of this policy option. Many thought that it meant the employers had to pay out $30,000 in health insurance expenses before the plan would begin to assist them; others thought that the employer would be responsible for paying the first $30,000 in benefit payments.

? Respondents also criticized participation requirements. They believed that the employee income caps were too low; that some employers of low-wage workers would not be able to afford half of the premium, and that it would be difficult to get half of the employees in low-wage firms to agree to sign up for the plan. Most also agreed that a $100,000 lifetime benefit cap was too low.

## VHAP Buy-In to Employer-Sponsored Plans

? This plan was described as one that would shift children from Dr. Dynasaur to a parents' employer-sponsored health plan. This would be done only in instances where it would be less costly to the state to pay the difference necessary to obtain family coverage on the private plan than to keep the child enrolled in Dr. Dynasaur.

? Initial reactions to this policy option were good. Participants liked the idea that the plan would save the state money and that it would assist individuals in affording private insurance. Many appreciated the individual-targeted approach.

? However, participants noted that Dr. Dynasaur benefits are often far superior to benefits available in an employer-sponsored plan. They also mentioned that the policy option would increase costs to individuals, because most employer plans have co-pays and deductibles, which individuals were not paying under Dr. Dynasaur. Participants looked significantly less favorably on the plan when they realized that, although the state would save money, individuals would end up with more out-of-pocket medical expenses.

? Participants were concerned that many parents would be unwilling to move their children from Dr. Dynasaur to an employer's plan. Questions were raised about whether people would be required to move their children, against their wishes. Many also wondered what would happen in cases where a parent is offered insurance, but chooses not to be insured for cost reasons. Would that person be required to pay the individual premium portion, so the state could shift the children to the employer plan?

? There were also concerns about the state's involvement in the administration of this plan. Most agreed they did not want the state making decisions about who should be on which insurance program. Many also anticipated a significant amount of bureaucracy and paperwork, requiring many administrative personnel. Many questioned whether the state had the current capacity for this additional work.

? Questions were raised regarding whether shifting a number of children from Dr. Dynasaur to private insurance would increase health insurance premiums for all. Many thought that this would be the case. However, consumer without insurance believed that adding more persons to private insurance policies would give employers more bargaining power to get lower premium rates.

? As with other policy options, many note that this plan does little to address the need for lower premium costs or more affordable health care. They also criticize the plan for being selective about who receives assistance, noting that this plan would only help those who are already offered health insurance and would do nothing for persons without access to insurance.

## Direct Care Model

? This plan was presented as one that would provide funding to expand the availability of free or subsidized health care for the uninsured.

? This policy option was perhaps the most confusing to nearly all of the groups. Many could not understand that this was not a health insurance program, nor could they understand how this program would work. Many were cynical about a doctor's or hospital's willingness to participate in another program that did not charge full fees for services. Participants used Medicaid and Medicare as examples and insisted that there would be no such thing as free care.

? Consumers without health insurance were not as confused by this policy option. They were slightly less cynical about doctor's and hospital's willingness to participate in such a system. Despite this, they had many of the same questions and concerns as those in other groups had.

? Participants believed that someone, somewhere, would end up paying for the care delivered under this model. Most believed the burden would fall upon taxpayers and insured persons in the form of higher taxes and higher premium rates.

? The perception is that doctors are already overbooked, because many people have difficulty getting in for appointments. Therefore, many questioned how doctors would be able to fit in new patients from this plan. Many also believe that doctors are reluctant to take Medicare and Medicaid patients, because of low reimbursement rates. Given this, they question a physician's willingness to take on more patients who would not be paying full cost for their services.

? Additionally, many believe that this option is targeted toward a group of people who are most likely already eligible for other types of assistance. Participants also mentioned that this program does not address the issue of affordable health insurance and care for all Vermonters.

? Despite the confusion over this model, many did praise it for getting people access to health care and helping them afford it. Many agreed that the plan would reduce the cost of caring for the uninsured by integrating them into mainstream care, getting access to preventive care and reducing the need for emergency room visits.

## Medicaid Eligibility Expansion

? This plan was presented as one that would expand the income eligibility levels for VHAP to 300% of the federal poverty level for all Vermonters. The increase would be implemented gradually.

? Many thought that this policy option was a good idea. They see that this policy option would achieve the goal of insuring more Vermonters, specifically addressing the needs of uninsured adults in Vermont. Many preferred this plan because it targeted individuals rather than employers. This plan was also seen as one that would address the need of Vermonters who work multiple part-time jobs or hold seasonal positions and, therefore, are not eligible for employer-sponsored health insurance.

? Again, participants took issue with some of the eligibility requirements. A few felt that 300% of the FPL was too high; however, most felt that 300% did not go far enough. Many thought that the eligibility levels should be increased at the same time for everyone, regardless of whether or not they have children.

? One concern voiced about this policy option is whether it would cause more people to drop employer-sponsored coverage, thus making it more difficult for employers to qualify for plans or to afford the premiums. Another concern is that this option will end up costing taxpayers more. Uninsured respondents and one group of employers who do not offer health insurance note that expansion of VHAP will increase the cost-shifting that occurs due to the reimbursement rates.

? Participants did mention they would like to see a gradual move off VHAP, rather than a strict cutoff. Respondents thought that those over 300% of the FPL should be allowed to participate in VHAP, but pay premium payments, deductible and co-pays. They envision that these payments would increase the higher one's income level was.

### *Comparing the Options*

? Each group was asked to rank the three policy options they evaluated in depth. Participants from businesses not currently offering insurance named the Employer Health Insurance Tax Credit as their first choice and the Low-Cost Insurance Plan as their second choice. The VHAP Buy-In was the third choice.

? Employers who are offering health insurance to employees were most likely to select the VHAP Buy-In to Employer-Sponsored Plans as their first choice. The second choice was the Employer Health Insurance Tax Credit and the lowest-ranked plan was the Low-Cost Insurance Plan.

? Generally, employers gave the highest ratings to the plans that they felt would benefit them most directly. In fact, many employers who do offer health insurance noted that they did not really prefer any of the plans, because none were targeted toward them and their struggles with offering health insurance.

? The consumers who have health insurance had very different opinions on which of the individual-targeted plans rated first. In Rutland, respondents named the VHAP Buy-In as their first choice; in Bennington, respondents preferred Medicaid Eligibility Expansion. Consumers without health insurance ranked the Direct Care Model and Medicaid Eligibility Expansion as their first choice.

? Near the end of each group, respondents were asked to vote on all five plans that had been presented and discussed. Two out of three indicated they would support the Employer Health Insurance Tax Credit and Medicaid Eligibility Expansion. Half supported the idea of the VHAP Buy-In to Employer-Sponsored Plans or the Direct Care Model. About one in three supported the creation of a Low-Cost Insurance Plan.

? Perhaps not surprisingly, employers who do not offer health insurance are most likely to support the programs targeted toward employers not currently offering insurance (Employer Health Insurance Tax Credit and Low-Cost Insurance Plan). Employers who do currently offer health insurance prefer the individual-targeted plans (Direct Care Model and Medicaid Eligibility Expansion). Interestingly, consumers who have health insurance spread their support among the Employer Health Insurance Tax Credit, the VHAP Buy-In and the Medicaid Eligibility Expansion; those without health insurance supported all of the plans except the Low-Cost Insurance Plan

# I. BACKGROUND

## A. Overview

The Office of Vermont Health Access commissioned The Lewin Group and Action Research to test market policy options developed by The Lewin Group as part of the work undertaken by the State of Vermont under the Federal HRSA State Planning Grant. This research was supported by a grant from the Health Resources and Services Administration, U.S. Department of Health and Human Services.

This phase of the research focuses specifically on qualitative testing of five specific policy options intended to increase Vermonters' access to health insurance. The research includes focus groups conducted with employers and consumers throughout Vermont. Action Research conducted a series of four focus groups with employers (41 participants) and two focus groups with consumers who have insurance (23 participants).

Focus groups with consumers who do not have insurance were also conducted (10 participants). Due to delays in conducting these groups, findings from the uninsured groups are presented in a separate section of the report. The section which presents these results is arranged differently than Section II because consumers without health insurance discussed three of the five plans in-depth (as did other groups). The plans discussed most are presented first.

The qualitative research had one specific goal: to present each of five policy options and obtain feedback from the participants. Specifically, the focus groups sought to determine participants' perceptions of the benefits and drawbacks of each plan, to explore questions participants had about each plan and to determine what changes participants would like to see with each plan. The research also sought to rank the plans by participant preference.

## B. Objectives

The research with employers addressed the following topics:

? In-depth concept testing for each of three options targeted toward the participants' group (e.g., the employer groups tested the employer-targeted plans in depth);

? Ranking of preferences for the three group-targeted plans;

? Brief discussion of the two other policy options;

? Gauging support for each of the five plans presented.

## C. Policy Options Tested

Below are the full text descriptions of each of the five policy options tested in the focus groups.

### Employer Health Insurance Tax Credit

The purpose of this program is to assist small employers who have low-wage workers in obtaining coverage for their employees. The program would provide a tax credit to eligible employers equal to 25% to 40% of the employer's cost of coverage (i.e., premiums paid less the amount paid by employees). The tax credit would be refundable, which means that eligible employers would receive the tax credit even if they did not earn enough to pay taxes. The tax credit would be available to firms meeting the following eligibility criteria:

- ? Firms with 25 or fewer employees;
- ? Firms that have not have provided coverage in the past 12 months;
- ? Firms that have average salaries or wages per employee below the statewide average.

### Low-Cost Insurance Plan

The purpose of this option is to make a low-cost health insurance product available to small firms that do not now provide coverage to their employees. Eligible employers would be permitted to purchase a private insurance policy that is exempt from state-mandated benefits requirements and is subsidized with state funds. The state-funded subsidy would be in the form of a "reinsurance" program where the state pays 90% of the cost of benefits payments in excess of $30,000 for persons covered under such a plan. These features would reduce the cost of the insurance by between 15% and 20%. The benefits excluded from the plan for eligible firms include chiropractic, home health care, drug and alcohol treatment, mental health and others. The plan would have a $500 deductible with a lifetime benefits limit of $100,000. Eligibility would be limited to firms that meet the following eligibility criteria:

- ? 50 or fewer workers with at least half enrolling in the plan;
- ? Firms that have not provided coverage in the past 12 months;
- ? Firms where less than 30% of the workers earn over $30,000;
- ? Firms where the employer pays at least half of the premium.

### VHAP Buy-In to Employer-Sponsored Health Plans

The purpose of this proposal is to enroll Dr. Dynasaur-eligible children in a parent's employer-sponsored health plan in cases where such coverage is available. Under this option, the state would identify children eligible for Dr. Dynasaur who also have a parent with access to employer-sponsored coverage where they work. The state would pay the premium contribution required to obtain family coverage under the employer plan in instances where this is less costly to the state than covering the children under Dr. Dynasaur. The amount paid to the employer would be equal to the difference between the contribution amount required for family coverage

and the contribution amount required for single coverage under the plan. This option has the added dividend of increasing coverage among parents as well as children. This is because the family coverage policies typically offered by employers cover the spouse of the worker as well, resulting in an automatic expansion in coverage for these parents with no additional cost to the state.

### Direct Care Model

The purpose of this program is to expand the availability of free or subsidized health care for needy individuals who continue to be uninsured. Uninsured persons who present themselves at hospitals would be permitted to obtain services from participating physicians during regular business hours in the physician's office. Participants would be required to pay for a portion of the services provided on a sliding scale with income for persons below 300% of the federal poverty level (FPL) (i.e., about $53,000 for a family of four). Case management would be provided for persons with chronic conditions.

### Medicaid Eligibility Expansion

Income eligibility levels for the VHAP program would be increased to 300% of the federal poverty level (FPL) for all Vermont residents. This corresponds to annual income of roughly $25,000 for a single individual and $53,000 for a family of four. Because children through 300% of the FPL are already covered under Dr. Dynasaur, this would affect primarily adults between the current VHAP eligibility level and 300% of the FPL. (The current VHAP eligibility is 185% of the FPL for parents living with children; and 150% of the FPL for adults without children.) The expansion would be implemented gradually. For instance, the expansion might begin by increasing eligibility levels for parents living with children to 200% of the FPL, then gradually increasing to 250%, etc. Then the State would consider expanding eligibility for adults without children.

## D. Methodology

To meet project objectives, Action Research conducted a comprehensive qualitative program that included a series of eight focus groups: four with businesses and four with consumers in five areas throughout Vermont. After discussion and consultation with The Lewin Group and Steering Committee members, it was determined that the focus groups were to be arranged as follows:

| | **Business Groups** | | **Consumer Groups** | |
|---|---|---|---|---|
| | **Offering Insurance** | **Not Offering Insurance** | **Have Health Insurance** | **Do Not Have Health Insurance** |
| **Burlington** | 1 | | | 1 |
| **Rutland** | | 1 | 1 | |
| **Newport** | | 1 | | |
| **Bennington** | 1 | | 1 | |
| **Middlebury** | | | | 1 |

High-level employees responsible for the administration of employee benefits (frequently the owner, president, vice president or human resources director) were recruited to participate in the discussion. Many of the participants in the business groups had attended the first round of focus groups conducted in February 2001 as part of the exploratory phase of the research. All employer focus group participants were offered a $100 stipend to attend.

Two focus groups were conducted with Vermonters who currently have health insurance and two focus groups were conducted with uninsured Vermonters. Participants were offered a $75 stipend to attend the discussion.

Each of the focus groups was composed of up to 12 individuals. The qualitative research for this phase of the HRSA project was conducted during July 2001. The following section contains a full report of the research findings for the first six groups (all the business groups and the two groups of consumers with health insurance). Section III contains the findings for the last two focus groups conducted with consumers without health insurance.

## II. REACTIONS TO POLICY OPTIONS AMONG EMPLOYERS AND CONSUMERS WITH HEALTH INSURANCE

In each of the six groups conducted, three policy options were focused on in depth and two were presented and briefly discussed. The options that were discussed in depth were those options targeted toward that specific group. For example, in the employer groups, the policy options that are primarily targeted toward employers, the Employer Health Insurance Tax Credit and the Low-Cost Insurance Plan were tested in depth; Medicaid Eligibility Expansion and the Direct Care Model were only briefly discussed since those plans are targeted specifically toward individuals. Medicaid Expansion and Direct Care were discussed in depth during the consumer groups, whereas the other two plans were briefly discussed. The VHAP Buy-In to Employer-Sponsored Health Plans was discussed in depth in every group, since it is targeted toward both employers and individuals.

Generally, the groups found the concepts difficult to digest and understand. During many of the groups, more time was spent describing and explaining elements of each plan than discussing the merits and drawbacks.

> *"A lot of this tonight was confusing at times." Consumers with Health Insurance, Bennington*

Both employers and consumers had many questions about each plan, the first of which was often *"How will this be paid for?"* Participants were told that we would not be discussing the details of funding each of these plans, and most were able to move past funding to evaluate the plans as written. However, in most groups, participants indicated at some point that they did not feel the policy options were addressing what they believe are the core issues at stake in insuring more Vermonters: affordable health care and affordable health insurance.

> *"We are not really addressing the problems in the state of Vermont in being presented with these programs." Consumers with Health Insurance, Rutland*

Health care and health insurance issues are very personalized issues for many people. Often when discussing the policy options, many participants related the plan to how it would effect their lives, personally. This was true in both the consumer groups and the business groups, where participants tended to individualize the options, in addition to reacting to how each option would effect them as business persons. At times, participants found themselves mired in the details of how a particular plan would effect their lives, rather than thinking about the larger picture of how the plan would effect the rate of insured persons in the state of Vermont.

> *"Right now I think we are all worried about ourselves. We should be worrying about some other people and how we are going to get them insured." Businesses Offering Health Insurance, Burlington*

## A. Employer Health Insurance Tax Credit

This plan was presented as a program to assist small employers with low-wage workers in obtaining health insurance coverage. The plan was described as one that would provide a refundable tax credit to the employer. (See Appendix II for the full plan description).

Participants envision that this policy option would make health insurance more affordable for both employers and employees. They see that this type of plan would assist small employers who have low-wage workers in being able to offer health insurance to employees. Even consumers agree that the Employer Health Insurance Tax Credit would encourage employers to offer health insurance to their employees.

> *"I think it does encourage employers who aren't currently offering it to offer." Businesses Not Offering Health Insurance, Rutland*

> *"This is the kind of plan that I would need because I do have low-wage workers and it is the kind of plan that would help me to help them." Businesses Not Offering Health Insurance, Newport*

> *"[A benefit of this plan is that it] might result in the coverage of low-wage workers." Businesses Offering Health Insurance, Burlington*

> *"Good idea. It might be an incentive, a really good incentive, to get small business people." Consumers with Health Insurance, Bennington*

Clearly employers are attracted to the idea of getting tax relief in exchange for offering health insurance to employees. Overall, employers who do not currently offer health insurance to employees feel slightly more favorable toward the concept of an Employer Health Insurance Tax Credit. However, most participants agree that offering businesses a tax incentive is a good idea.

> *"I like the tax credit. I think that there is a direct benefit." Businesses Not Offering Health Insurance, Rutland*

*"Everybody likes a tax credit, especially if you can refund it." Businesses Not Offering Health Insurance, Newport*

*"It just feels better because it is money coming back." Businesses Offering Health Insurance, Bennington*

A few participants stated that this policy option has the added benefit of allowing employers to choose which plan they would like to offer their employees and give them the option of changing plans or shifting the benefit structure as an employer sees fit.

*"This plan leaves some of the freedom of choice to the employers and the employees in that they obviously choose their own insurance program." Businesses Not Offering Health Insurance, Rutland*

Participants, particularly employers, felt that the tax credit should be increased to 40%-60% of the employers' cost of coverage. Some suggested that the federal government also contribute to the tax credit to reduce the overall cost burden to the employer.

*"You could increase the percentage, play with the figures. [An increased percentage] would be more incentive for employers." Businesses Not Offering Health Insurance, Rutland*

*"If we can get a kickback from the federal government . . . it would be even more pleasing to an employer. At least if the federal government were to kick in 20%, then you are talking 50%. That is a little more agreeable." Businesses Not Offering Health Insurance, Newport*

Many participants state that, although they like the idea of the Employer Health Insurance Tax Credit, this plan does little to address an employer's need to find an affordable health insurance plan. Participants note that, while a tax credit would help, many employers cannot afford the monthly cash output necessary to fund a health insurance plan.

*"This is actually a great plan, but you have to fall back and look at it as an employer . . . now I have to go out and find a plan that my employees can get into that I am not going to be killed with a premium." Businesses Not Offering Health Insurance, Newport*

*"This has not solved the health care insurance problem, it is just helping you afford it." Businesses Not Offering Health Insurance, Newport*

*"The employers are putting up the money throughout the whole year and they're only getting it at the end of the year. Whereas, if a plan were low-cost it would not be as much up-front cost to the employer." Businesses Not Offering Health Insurance, Rutland*

*"I don't think this takes into account that the companies need the money in the front end in order to make it happen." Businesses Offering Health Insurance, Burlington*

Respondents had particular criticism for the eligibility requirements. Many felt that the Employer Health Insurance Tax Credit plan should be available to all employers, not just those who meet specific criteria. However, a number of participants also noted they felt the largest, most successful companies in the state do not need a tax credit because they can afford to offer health insurance.

> *"The idea is there, it just needs to be tweaked so it is open to all small businesses." Businesses Offering Health Insurance, Burlington*

Most participants wanted to know what the statewide average wage was. Participants noted that the requirement for a business' average wages to be below the statewide average may be difficult for many firms to meet, given that competition for employees has driven up wages. In the Burlington focus group, participants noted that, since Chittenden County wages tend to be higher than the state average, this requirement would preclude many Chittenden County businesses from taking advantage of the plan. A number of participants felt this requirement provided a disincentive for employers to pay employees a livable wage.

> *"That is great for most businesses outside of Chittenden County." Businesses Offering Health Insurance, Burlington*

> *"You are encouraging employers to pay low wages." Businesses Not Offering Health Insurance, Rutland*

Participants felt, at the very least, that the "average wage" used as a criterion should be based on countywide wages or industry-wide wages. Participants did not believe that companies in Orleans County should be held to the same average wage standard as companies in Chittenden County. Likewise, they felt that companies in the high-tech industry should not be measured by the same wage criteria as those in the hotel or restaurant industry.

Respondents saw another issue that this policy option does not address: the fact that many low-wage workers prefer higher wages to health insurance benefits. Participants note that often firms that do not offer benefits pay higher salaries to compensate, and workers prefer this arrangement. Such companies would not fit the average wage requirement and, most likely, would not be able to reduce the wages they are currently paying to adjust for offering health insurance in order to qualify for this plan. Some were concerned that they would have to lower their wages to qualify for this plan.

> *"My people want more cash up front. They are not going to accept low pay in [return for] insurance." Businesses Not Offering Health Insurance, Rutland*

> *"Employees do not want the health insurance plan, by and large. What they'd like is a little more money in their pocket." Businesses Offering Health Insurance, Burlington*

> *"Does that say that if I want to take advantage of this and offer my employees insurance, does that mean that I am going to have to pay them less?" Businesses Offering Health Insurance, Bennington*

For some employers, the fact that this plan is targeted toward low-wage workers is a positive element of the plan, because they believe there are many people who fall into that category and could use some assistance.

> *"I like the part that the salaries or wages of employees are below [average] because there are a lot of places that pay below [average]. Anything that could help." Businesses Offering Health Insurance, Burlington*

Participants had several concerns about the criterion that limits participating firms to 25 or fewer employees. Many believed that the limit should be raised to firms with 50 or fewer employees. Some employers expressed concern that the 25-employee limit would discourage companies from expanding and hiring more people.

> *"Does this become restrictive to businesses that are trying to grow? If I've got 25 employees and I am thinking about bringing on one more, do I not do that because I would no longer be eligible for these tax credits?" Businesses Offering Health Insurance, Burlington*

Many had other questions about the eligibility criterion of 25 or fewer employees. They were unsure whether full-time employees or all employees were considered in that number. Would the 25 include part-time and seasonal workers? What about employees who are not eligible for health insurance, or those who receive their health insurance from another source? Many thought that "25 employees" meant 25 employees would be eligible for a health insurance plan. For some that would be preferable to counting every type of employee toward the 25.

> *"The 25 would be okay if they only used those that are full-time. We have college kids and stuff, we have over 30 employees. But full-time we only have about 20. The rest are summertime workers, students or are not eligible for our health plan." Businesses Offering Health Insurance, Burlington*

Many participants, even those employers who currently do not provide coverage, felt that the eligibility requirement of having not provided coverage in last 12 months was not fair. Participants feel this criterion prevents many people who need assistance from being able to obtain it. They recognize that many employers who are offering health insurance are struggling to be able to afford it.

> *"You are only offering it to firms who have not provided coverage in the past 12 months. It does not cover those middle-of-the-road people that have a tough time, too." Businesses Not Offering Health Insurance, Rutland*

> *"I think that is not fair. Why not open it up to those who offer their employees benefits also? I understand this is trying to get them to offer it, but this would also help others." Consumers with Health Insurance, Bennington*

> *"[This plan] penalizes employers for paying a decent wage and offering insurance." Businesses Not Offering Health Insurance, Rutland*

Perhaps not surprisingly, employers who are currently offering insurance were the most vocal about the inequity of this particular requirement. They resent the fact that they have been struggling to *"do the right thing"* by offering health insurance and are now not going to be eligible for assistance because they have been offering insurance. This policy option offers a helping hand to their competitors, putting them at a disadvantage.

> *"If you are already offering it, this does not hit home. It makes you mad." "There may be other firms out there that are really pinching to make sure that their workers do get coverage. To see this come in, quite frankly, makes me very angry." "The people that have been anteing up are not getting any benefit from this. And [the company benefiting from this plan] could be a competitor!" Businesses Offering Health Insurance, Bennington*

Many suggest that the eligibility criteria be amended to include those who are currently offering insurance and having a difficult time affording it. Some suggest that these employers be allowed to apply to take advantage of this policy option for a brief period of time when the policy is introduced. Others suggest considering a firm's plan participation rate and offering tax credits to those firms with low participation rates, so that the company can afford to offer better benefits or increase the employer share of the premium. Still others would like firms to be eligible if they start offering insurance to groups of employees previously considered ineligible, such as part-time or seasonal workers.

> *"Perhaps you could incorporate language that recognizes marginally operating employers that are doing what it takes, reducing their profit margins to provide insurance to their employees. They should be held, perhaps, in a different light than the company that is saying 'Screw them, I want 15% [profit] and there is no health insurance.'" Businesses Offering Health Insurance, Burlington*

A number of participants indicated that they themselves would not be eligible for the Employer Health Insurance Tax Credit, because they did not meet one or two of the eligibility criteria.

> *"It is a great plan but it really restricts an employer like myself to be able to enroll because I have more than 25 people and we pay above-average salaries and wages in our company. I mean, you have to be competitive in your industry to get employees." Businesses Not Offering Health Insurance, Newport*

Another drawback that participants see is that, although this plan helps employers afford health insurance, it does not help employees pay their share. Some would prefer to see tax credits targeted toward individuals. Consumers observe that this plan would only help address the needs of people who are working.

> *"This is a beginning, I guess. It still think a tax credit to the employee would be a better solution." Businesses Offering Health Insurance, Burlington*

> *"It is a good idea, but it still does not address everyone." Consumers with Health Insurance, Bennington*

A few also note that this plan does not encourage employers to offer a "good" insurance plan to employees, nor does it address the problem of people being underinsured, or having health insurance but still not being able to afford care because of co-pays and deductibles.

Some participants had difficulty understanding that this policy option was not a health insurance plan, but rather a tax credit that applied to any plan an employer chose. Some employers wanted to know what benefits this plan would cover, what the deductible and co-pay would be and, most importantly, what the monthly premium would be.

> *"It all depends on what the costs are." Businesses Not Offering Health Insurance, Rutland*

## B. Low-Cost Insurance Plan

This policy option was described as a low-cost insurance product for small firms that do not now offer health insurance. The low-cost plan would exclude state-mandated benefits and would be subsidized by the state in the form of a reinsurance program. (See Appendix II for full description of the plan.)

Overall, participants thought this might be a good option for those who do not have any other options. Many indicated they liked the idea of a low-cost plan being available. Some indicated they thought targeting such a plan toward lower-income workers and employers not currently offering insurance was also a good idea. Many also liked the idea that the state would be getting involved in helping businesses afford health insurance.

> *"Well, I think if the plan is going to help insure people that are not going to have insurance otherwise, it is a good idea." Consumer with Health Insurance, Rutland*

> *"The good points I see are low-cost health insurance product and a subsidy. I mean, at least that kick-starts a viable program that the small business person can get involved in." Businesses Not Offering Health Insurance, Rutland*

> *"The state is going to contribute, to play a role in something." Businesses Offering Health Insurance, Bennington*

However, for most participants, this plan was viewed as only a moderately adequate solution to the health insurance problem facing employers. Participants felt that the benefits exclusions and the eligibility requirements of the plan limited its effectiveness as a good solution.

> *"It is a basic program that is much better than a lot of people in this state have. It is much better than nothing, something is better than nothing." Businesses Not Offering Health Insurance, Newport*

> *"It is better than nothing if they don't have anything." Consumers with Health Insurance, Rutland*

*"It is better than nothing." Businesses Not Offering Health Insurance, Rutland*

*"My first reaction is, it is better than nothing." Businesses Offering Health Insurance, Bennington*

A few participants recognized that, while this plan does not provide coverage as generous as that of other plans in the commercial marketplace, it is an attempt to assist those who have no insurance at all.

*"[This plan] may be inadequate relative to what is out there in the private sector, but is not inadequate if it is being made available to people who could not get anything at all. So this is a reasonable attempt at providing benefits." Businesses Offering Health Insurance, Bennington*

Some participants were upset that a plan of this nature was being targeted toward low-income persons. They felt that although this plan is *"better than nothing,"* it is unfair for those who can't afford health insurance to be offered a plan that is *"inadequate."*

*"Why should the people that need the most help get the worst coverage because it is 'better than nothing?' Why come up with something that is really inadequate? Why not do it the right way?" Businesses Offering Health Insurance, Bennington*

Some believe the Low-Cost Insurance Plan option would encourage some employers to begin offering health insurance. However, most note it would depend on how much the plan costs. Many stated that the 15%-20% savings would not be enough to get businesses interested in the plan. Participants noted that health insurance premiums are being raised 15%-25% each year. Therefore, a 15%-20% savings would benefit an employer only in the short term, because premium rates would rise quickly. Some participants suggested that the savings on the premiums be increased to half the cost of today's plans.

*"The golden key to every employer, is what is that 50% [of the premiums] going to amount to?" Businesses Not Offering Health Insurance, Newport*

*"Is 15% less going to be enough? Because that does not really qualify as low-cost. If something is going to cost you $500 a month and it drops to $425, I mean, it is a help but it is not really low-cost." Businesses Not Offering Health Insurance, Rutland*

Again, participants had many questions about the policy option and exhibited a significant amount of confusion over elements of the plan. Perhaps most confusing for respondents was the paragraph describing the reinsurance program. Many employers interpreted this paragraph to mean that they had to incur a cost of $30,000 before this plan would kick in and help them afford health insurance. Others thought that the employer would be responsible for the first $30,000 in benefit payments, before the state would take over. Respondents, even those who correctly understood the reinsurance program, were confused about who would be responsible for covering the 10% of benefit payments not covered by the state.

*"That $30,000, if I am reading this right, that is saying we the employers have to put in $30,000 before they start contributing to this plan." Businesses Not Offering Health Insurance, Rutland*

*"It is unclear what it really is." Businesses Not Offering Health Insurance, Rutland*

*"Who is responsible for the other 10%? The diseased? The employer? The insurance company?" Businesses Offering Health Insurance, Bennington*

Other questions raised by participants were whether employers had to pay half of the *individual* employee premium or half of a *family* premium. Many employers noted that they currently offer to pay a portion of an individual employee's health insurance, but that if an employee wishes to have family coverage, they have to cover the entire difference. Participants also asked whether the deductible mentioned for this plan was $500 per person or $500 for everyone on the plan.

In participants' eyes, one of the major drawbacks to this plan was the exclusion of benefits listed. In every group, participants expressed concern that the plan would deny access to these coverages for people who were on this plan. Most agreed that the listed benefits (chiropractic, home health care, drug and alcohol treatment, mental health and others) should be included in a health insurance plan. This was a departure from earlier findings when participants clearly stated they felt Vermonters should be able to purchase a health insurance plan free of state-mandated benefits.

In addition to their reaction to the Low-Cost Insurance Plan being a complete departure from earlier findings, participants often contradicted themselves during these groups, indicating that the idea of excluding services to obtain a lower-cost plan is a good idea; however, they felt the services listed were necessary services. Participants noted they have a lot of people working for them who use chiropractic, home health care, and drug and alcohol treatment. They believe these services should be covered because they are too expensive for people to pay for themselves.

Participants note that often, it is less expensive to utilize services such as chiropractic and home health care to treat people.

*"Sometimes it is a lot cheaper for a chiropractor to solve a problem, than to have someone go under the knife and then be out of work for six months." Businesses Not Offering Health Insurance, Newport*

*"The cost to put someone in a nursing home or long-term care facility is three times what it costs to go into their home." Businesses Offering Health Insurance, Burlington*

*"It is discriminating against a population." Businesses Offering Health Insurance, Burlington*

In light of the departure from earlier findings, respondents were asked to discuss their reactions to the Low-Cost Insurance Plan in the context of previous discussions where most had clearly

stated their desire to be able to obtain a health insurance policy free of state-mandated benefits. Respondents indicated that it was not simply that they wanted one policy available to a limited number of people, but that they felt the state should deregulate the entire health insurance industry and allow companies to not cover specific treatments.

> *"We were talking about deregulation, increasing competitiveness. Having five or six companies competing for a buck, rather than a monopoly. That is what we were talking about. The government staying out of the way." MODERATOR: "So, this does not work in terms of offering a lower-cost insurance plan that is free of state mandates?" PARTICIPANT: "Not in my opinion, no." Businesses Offering Health Insurance, Burlington*

Some respondents say that, although in February they did say wanted a plan free of state-mandated benefits, they did not realize the extent of the benefits that would be excluded. Specifically, many respondents were concerned about the exclusion of home health care and drug and alcohol treatment. Most indicated that when they said they wanted a mandate-free option, what they really were talking about was deregulating for more competition so that plan prices would drop. They want an affordable policy, but they, personally, want to have a policy with those benefits included.

> *"Maybe the group as a whole [the mandated benefits] is a little daunting to see all of those things." Businesses Not Offering Health Insurance, Rutland*

> *"I just want the rates to come down." Businesses Offering Health Insurance, Burlington*

> *"It depends on how you're looking at it. If you want a really cheap policy, I guess you have to drop some of those things, but on the other hand, we would all prefer to be able to have those things at an affordable price." Businesses Not Offering Health Insurance, Rutland*

A few participants thought that the benefits exclusions were acceptable. However, many qualified that response by noting that the exclusions are okay in terms of achieving a *"cheap"* health insurance plan, but they themselves would not want to be covered by such a plan.

> *"I did not realize that Vermont had such state mandates. [I thought that health plans that offer the state-mandated benefits] are health plans that offer the best of the best. Maybe that is not what everybody needs." Consumers with Health Insurance, Bennington*

> *"The fact that it is somewhat away from the state's mandates helps a little, because some of the state's mandates I think have driven up the cost of health care to begin with." Businesses Not Offering Health Insurance, Rutland*

> *"You are not going to get a cheap health care plan and cover all the extras. I am saying this plan is okay if you want to go cheap. I am <u>not</u> saying it is an okay plan. It is okay if*

*you want to go as cheap as possible and still have some coverage." Businesses Not Offering Health Insurance, Newport*

Some note that their employees use chiropractic and mental health services and the employees would be upset if they were not offered the coverage. A few employers stated that the state requires them to have a drug and alcohol treatment program available for their employees. If this were not available through health insurance, they would have to go out and purchase additional coverage. Ultimately, employers noted that they would not be likely to adopt a plan that would not be attractive to their employees.

*"Almost 80% of our employees use chiropractic services. The others are on antidepressants. Those are the people who use the health plan." Businesses Offering Health Insurance, Burlington*

*"[This option] would not encourage me. If the plan is not more attractive, then even the employees may not sign up for it, even if employers offer it." Businesses Offering Health Insurance, Bennington*

Most participants also saw the eligibility requirements as a drawback in this option. Most participants had a problem with at least one of the eligibility requirements; many had problems with several of the requirements.

First, most groups indicated they felt the earned income requirements (that fewer than 30% of the workers earn over $30,000) were too low. The general consensus was that this plan should be open to employers who paid higher wages than this requirement would allow. Some participants, again, saw the earnings criteria as a disincentive to employers paying higher wages.

*"Say there is a company with three people, and one of the guys earns $32,000, which really isn't diddly anyways. This would exclude that company. They are trying to make a benefit program for small companies, yet they are trying to financially exclude some also." Businesses Not Offering Health Insurance, Rutland*

*"I think they should include [the excluded] benefits and raise some of the limits as far as the salaries go." Consumers with Health Insurance, Bennington*

*"That is a disincentive, a socialist disincentive, to increase wages." Businesses Offering Health Insurance, Burlington*

A few participants also rejected the idea that an employer should be required to pay half of the premium, noting that half the problem for companies that do not offer health insurance is that they cannot afford to pay the premiums in the first place.

*"Some employers could not afford to pay half of the premiums." Businesses Offering Health Insurance, Bennington*

For some, particularly those who are not currently offering health insurance to employees, the requirement that half a company's employees sign up for the plan is a problem. They note that many employers experience problems with this requirement now. Respondents are also confused about whether the number of workers requirement means half of all employees, half of all full-time employees or half of the employees who would be eligible for a health insurance plan.

> *"I don't think it should have anything to do with half of the people enrolling in the plan. Why should I not get insurance if the other half of the people don't want it?" Businesses Not Offering Health Insurance, Rutland*

> *"That is the problem you have now. A certain percentage of those people have to take the plan, otherwise we can't get anything. That stinks too." Businesses Not Offering Health Insurance, Rutland.*

> *"I have a problem with the half of the employees. You don't have the numbers. With most insurance companies you have to have at least 75% participation to get into the plan. [You are still running up against that limitation.]" Businesses Not Offering Health Insurance, Newport*

> *"Does that eliminate people who already have insurance through a spouse? Is it just half of the eligible employees or is that half of all of your employees have to join?" Businesses Not Offering Health Insurance, Newport*

As with the Employer Health Insurance Tax Credit, participants roundly criticized the eligibility requirement for firms to have not offered health insurance coverage for the past 12 months. Again, many expressed that this eligibility requirement is not fair to employers. Those who are currently offering health insurance are particularly upset that their competitors could get a helping hand from the state, while they continue to struggle to afford health insurance. They are concerned that all employers need relief from increasing health insurance costs.

> *"I don't like the fact that it is only available to people who have not provided coverage before. I think that anybody who meets the criteria should be able to do it." Businesses Not Offering Health Insurance, Rutland*

> *"I've got to stop my health insurance for a year to be eligible?" Businesses Offering Health Insurance, Burlington*

> *"Somebody has been paying for insurance and all of a sudden, they are not eligible for this. Now you've got two classes [of business]. You've got a company that is being subsidized by the state and another company that is still struggling on their own." Businesses Offering Health Insurance, Bennington*

Another significant drawback participants saw in this plan was the $100,000 lifetime benefits limit. Most agreed that $100,000 did not constitute a significant amount of funding in today's health-care dollars. One person suggested increasing the lifetime limit to $300,000; another

stated there should be no limit. In the eyes of many, this limitation added to the possibility that employees would not find this an attractive enough plan to want to buy in to.

> *"The numbers are too low." "A hundred thousand is way too low." "With the cost of health care today, that could be blown away in less than one illness." Businesses Not Offering Insurance, Rutland*

> *"The lifetime benefit is too low." Businesses Not Offering Insurance, Newport*

> *"It is almost like pseudo-catastrophic insurance, but it is not catastrophic because of the $100,000 lifetime cap. So it is not really much of anything." Businesses Offering Health Insurance, Burlington*

> *"This is totally cosmetic. Just $100,000 lifetime coverage? Come on, it is not even worth paying premiums for." Businesses Offering Health Insurance, Bennington*

A few participants felt the deductible is too high, given the lower-income worker this plan is targeting. However, most thought that a $500 deductible was acceptable.

> *"If I look at the average employee who is making $30,000 a year, they can't afford a $500 hit." Businesses Not Offering Health Insurance, Newport*

Generally, participants viewed this plan as *"okay."* Consumers and employers who already offer health insurance question what the incentive to offering this plan would be. Most indicated it would not go very far in terms of helping a great number of people solve their affordable health insurance problems. Overall, participants want to see a low-cost insurance plan that does not exclude people from participating and includes home health care, drug and alcohol treatment and, for some, chiropractic care.

> *"There just does not appear to me to be any incentive for me to do this other than the fact that it might cost a little bit less." Businesses Offering Health Insurance, Bennington*

> *"This is a low-cost, basic plan. Which is okay, but it is basic. It does not give a lot of things. It is not going to help a lot of people." Businesses Not Offering Health Insurance, Newport*

> *"Increase the benefits." "More people have to be eligible." Businesses Not Offering Health Insurance, Rutland*

## C. VHAP Buy-In to Employer-Sponsored Plans

This policy option was described as enrolling Dr. Dynasaur-eligible children in their parent's employer-sponsored health plan, in cases where such a plan is available. This option indicated that the state would identify the instances where having a child on a parent's employer's health plan would be less costly than keeping that child on Dr. Dynasaur. The state would pay the

difference required for parents to obtain family coverage. (See Appendix II for full plan description.)

Initial reactions to this plan were positive. Participants saw that buying in to employer-sponsored plans would save their tax dollars in the long run and they liked the idea of the state assisting individuals in affording private insurance.

> *"It seems as though the state would save a tremendous amount of money." Businesses Not Offering Health Insurance, Rutland*

> *"The state would save money." Businesses Offering Health Insurance, Burlington*

> *"There may be a benefit to taxpayers." Consumers with Health Insurance, Rutland*

Participants also saw that this plan would assist families, rather than employers. They appreciated the individual-targeted approach. Some found the idea of covering kids privately more attractive than having children on state-funded plans. Most felt that the capture of a spouse at no additional cost would be one of the best benefits of this option. A few questioned whether it would, indeed, be more affordable to cover an entire family.

> *"This plan helps families, by switching them from a single plan to a family plan." Businesses Not Offering Health Insurance, Newport*

> *"It sounds like a great idea, more [people] covered with equal or lower costs. The problem is, well, it just sounds a little Alice in Wonderland to me. Almost too good to be true." Consumers with Health Insurance, Rutland*

> *"One of the benefits is that this would pick up the other spouse." Consumers with Health Insurance, Bennington*

One employer mentioned that he felt this policy option would increase employee loyalty, by bringing entire families into an employer-sponsored plan. He felt that, as a result, employees would feel more like a part of the company.

> *"Wouldn't you want to bring the whole family into your company business instead of having just one person in the family covered under your plan? You are more apt to hold on to good employees." Businesses Not Offering Health Insurance, Rutland*

However, shortly after their initial positive reaction, participants began to discuss the benefit structure of Dr. Dynasaur versus the benefit structure of most private insurance plans. Most participants pointed out that Dr. Dynasaur has an extremely generous benefit structure, whereas few commercial plans offered by employers cover the same level of benefits. At this point, many participants began to voice doubt about a parent's willingness to move a child from Dr. Dynasaur to a commercial plan.

*"If people are losing certain [benefits] that their kids won't get, then [this plan] would not be of much use to them." Consumers with Health Insurance, Bennington*

*"I have an employee with kids on Dr. Dynasaur. He would not be willing to put his kids on our plan, because he has much better coverage through Dr. Dynasaur. This guy said to me 'I want to take my kids off [the company plan] because I can get Dr. Dynasaur.' [Kids on Dr. Dynasaur] get so much more than [the company] can offer." Businesses Offering Health Insurance, Rutland*

*"It is not going to be as good a coverage. " "Nobody is going to be interested, it is too expensive to go buy the same coverage." Businesses Not Offering Health Insurance, Rutland*

*"The employee is getting less benefits." Businesses Offering Health Insurance, Burlington*

During this discussion, participants also brought up the fact that moving children into private insurance plans will cause families to incur more out-of-pocket medical expenses, because most commercial plans have deductibles and co-pays. While participants appreciate that the VHAP Buy-In to Employer-Sponsored Health Plans would not cost the state any more money, they feel considerably less favorable toward the plan when they realize that it would increase costs for individuals. Participants further note that in addition to increasing costs, this option means that those who are shifted under this plan will also receive fewer benefits.

*"What it does not take into consideration is that under Dr. Dynasaur there is no deductible, whereas there is typically always a deductible, and sometimes multiple deductibles, under a private plan." Businesses Offering Health Insurance, Burlington*

*"This will increase my costs as an individual." "Let's say the family plan has a $100 or $300 deductible per person per year, the individual gets hit with the deductible. The employer gets the credit [for the premium]." Businesses Offering Health Insurance, Burlington*

*"I feel like losing Dr. Dynasaur for lower-income families is going to hurt. Because their medical expenses are going to rise. You've got your co-pays, you've got your prescriptions, you'll start paying certain percentages. It will increase because Dr. Dynasaur is 100%, right?" Consumers with Health Insurance, Bennington*

Questions were raised about whether people would be forced to take their children off Dr. Dynasaur, even if they preferred to leave their children on the state-sponsored plan. Respondents also wondered what would happen in instances in which a parent has access to an employer-sponsored plan, but chooses not to purchase it for financial reasons. Would such individuals be required to pay for the individual portion of the health insurance, even if they would prefer to remain uninsured? In these cases, would their children still be eligible for Dr. Dynasaur?

*"Would this be mandated?" "Would you have to switch?" "If my kids are on Dr. Dynasaur is the state going to come in and say, 'We are taking that away and you have to go over here to Great West'?" Businesses Offering Health Insurance, Burlington*

*"What about those who were not on any plan, since they did not want to pay any money? Would they have to at this point?" Consumers with Health Insurance, Bennington*

A number of focus group participants were skeptical of the motivations behind this policy option. Some think that this plan is not necessarily geared toward assisting individuals in affording health insurance, but rather is a self-interested move on the part of the state to reduce the amount of money the state spends on health care.

*"Basically, this is another cost shift. The state of Vermont is looking for a way of getting out of spending as much money. They want to put it back onto the employee who is in a program." Businesses Offering Health Insurance, Burlington*

*"With Dr. Dynasaur, the state pays the whole thing. With this here, if a single policy costs you $300 and the family costs $500, the state is only going to pay $200. They are getting out of it cheap." Businesses Not Offering Health Insurance, Newport*

Some participants took the introduction of this plan to mean that the state is planning to discontinue Dr. Dynasaur. A few participants believed that the Dr. Dynasaur program has become very expensive and, therefore, the state is looking for ways to eliminate the plan.

*"It appears to me this is one way to get a lot of kids out of Dr. Dynasaur." Businesses Not Offering Health Insurance, Newport*

*"Would they eliminate Dr. Dynasaur?" Businesses Offering Health Insurance, Burlington*

*"Dr. Dynasaur is an extremely costly program and if they don't restructure it, we probably won't have it in a couple of years, which would mean a lot of uninsured children in Vermont. So what they are doing is taking children off Dr. Dynasaur and putting them on the parent's insurance program, which is a real step in keeping Vermonters insured." Consumers with Health Insurance, Rutland*

A few participants expressed doubt that it would be more affordable to insure an entire family than it would be to keep a child on Dr. Dynasaur. Most certainly, participants stated, one would not be able to find equal or better coverage at a more affordable price.

*"I will bet you a month of my salary if you run the numbers, that you will find that it is not going to be cheaper in a majority of the cases." Businesses Offering Health Insurance, Burlington*

*"I don't think that you can get less costly insurance that is better." Businesses Not Offering Health Insurance, Rutland*

Initially, some participants expressed concern that children whose parents do not have employer-sponsored programs would be left without health insurance if this plan were to be implemented. These participants did not understand that Dr. Dynasaur would continue to exist, they understood the plan to mean that all children on Dr. Dynasaur would be moved to a parent's plan. Others expressed concern that some children would become uninsured because of this plan – that they would be deemed eligible for the buy-in and taken off Dr. Dynasaur, but then their parents would not be able to keep the child on a private health plan.

> *"The employer has to offer some kind of health insurance in order for the children to be insured. I don't think that is right. I think all children should be insured." Businesses Offering Health Insurance, Burlington*

> *"How many kids are going to fall through the cracks between the two programs? How many of them actually get moved and how many fall through the cracks in the process?" Consumers with Health Insurance, Rutland*

Another concern raised regarding the VHAP Buy-In is the state's involvement in the administration of the plan. Participants were concerned about the idea that the state would be involved in making insurance decisions for individuals and that the state would become involved with businesses in terms of determining eligibility. A number of participants were concerned that the paperwork and bureaucracy would be a significant headache for both individuals and employers.

> *"I would be very hesitant to see the state making decisions about the quality of my children's lives." Businesses Offering Health Insurance, Burlington*

> *"Who is going to come in and determine? Is the state going to come into your business and look at your records?" Businesses Not Offering Health Insurance, Rutland*

> *"Who is going to do this? Is there capacity available for [the state] to do that?" Businesses Offering Health Insurance, Bennington*

Some participants expressed concern about how the Buy-In would affect private insurance rates; others wondered about the additional cost employers would incur under this plan. Some wondered if private insurers would raise their premium rates because they would be covering more lives once children were shifted over to private plans. Others rationalize that more people covered by private insurance will increase utilization and, therefore, will increase costs to individuals.

> *"Is this going to make the insurance companies raise rates even more because now even more children are going to be going to the doctor?" Businesses Offering Health Insurance, Bennington*

> *"The more utilization, the higher the cost for everyone else." Consumers with Health Insurance, Bennington*

As for the increased costs to employers, many groups did not even mention it during the discussion. However, some noted that employers would, indeed, incur higher health insurance expenses due to the fact that they would have to pay the employer split for any persons who opted to enroll in a family plan. While some thought that this might hurt employers, others noted that employers would not be paying any more than they are already willing to pay, because this plan would only cause them to incur costs based on the benefit structure employers already offer.

> *"Would this affect the employers? Are they going to have to pay higher premiums or make a larger contribution to cover the additional people?" Consumers with Health Insurance, Rutland*

> *"It seems like you can get families covered for basically the same cost to the employer." Businesses Offering Health Insurance, Bennington*

As with the other policy options evaluated, many participants noted that this plan does not address the need for lower premium costs or more affordable health care and health insurance. Participants also criticize this plan for being too selective in the type of people who will get assistance from the state. Ultimately, they note, this is not a plan that would help a lot of Vermonters afford health insurance.

> *"This is not something for everybody." "It is selective." Businesses Not Offering Health Insurance, Newport*

> *"It does not address a lot of the problems we discussed earlier [covering young adults, part-time workers, lowering health care and insurance premium costs, etc.]." Consumers with Health Insurance, Rutland*

Specifically, participants see that this policy option does not address middle-class Vermonters and their needs for more affordable health care. Participants point out that there are many people without dependent children who also need assistance.

> *"It does not deal with people without children." Businesses Not Offering Health Insurance, Newport*

> *"This does not address any person who does not have a dependent child under the age of 18." Businesses Offering Health Insurance, Burlington*

> *"It does not address the families that don't have children or do not have employer-sponsored coverage." Consumers with Health Insurance, Bennington*

Many participants point out that the VHAP Buy-In offers assistance only to persons who already have access to health insurance. Because of this, participants think this option is misdirected in that it does not address the needs of individuals most in need of help.

*"This is only addressing people that are already insured." "It is missing the most important people: those who do not have access to insurance." Businesses Not Offering Health Insurance, Rutland*

*"We are dealing with benefits of individuals who already have insurance. It is still leaving a lot of uninsured individuals." Consumers with Health Insurance, Rutland*

Some of the employers had a difficult time making the switch from evaluating employer-targeted plans to evaluating individual-targeted plans. Many employers considered the VHAP Buy-In plan and determined that this plan offered little or no incentive to get employers to offer their employees health insurance.

*"To me, this plan is just about saving the state money, not about helping employers provide coverage." "There is absolutely no incentive or benefit here for an employer to start a plan or to provide better coverage." Businesses Not Offering Health Insurance, Rutland*

*"It really caters to the employers that are already giving insurance. It is not going to help the ones that are not giving it to anyone. It does not give any real incentive." Businesses Not Offering Health Insurance, Newport*

*"It appears to be a pretty decent plan. But, again, it does not address the situation of the small company that does not have insurance." Businesses Offering Health Insurance, Burlington*

*"I'm not sure this plan is enticing employers to offer insurance." Businesses Offering Health Insurance, Bennington*

Despite many reservations and concerns about this plan, respondents ultimately thought the VHAP Buy-In was a fairly good idea, especially if it were to be combined with other programs that would target assistance toward individuals not assisted by the plan. Participants also felt that no one should be required to move their children from Dr. Dynasaur.

## D. Direct Care Model

This policy option was described as one that would expand the availability of free or subsidized health care for the uninsured. It was described as a plan that would allow the uninsured to obtain medical care at a physician's office and would require some participants to pay for a portion of services based on a sliding fee scale. (See Appendix II for the full plan description.)

Participants were very confused about this policy option. Many could not understand that this was not a health insurance program, but rather a program designed to assist the uninsured in obtaining health insurance through traditional health care channels, rather than through emergency rooms or clinics. Most could not comprehend a plan that did not require some premium-type payment in order to participate.

*"Is there a fee for participation?" Businesses Offering Health Insurance, Bennington*

Participants were very confused about how such a program would work in reality. How would "needy" be defined? How would participants get in to see doctors? Why would doctors agree to participate in a plan? How could free or subsidized care actually work? Many participants thought that this plan would deny people access to care in the emergency room, and make them wait until they could get into a doctor's office to obtain care.

*"A patient shows up at the hospital, are they going to feel like they are being dumped somewhere else because they do not have insurance?" Consumers with Health Insurance, Bennington*

*"This kind of says, you come at business hours or don't come at all. That's the way I read it." Consumers with Health Insurance, Rutland*

A few participants did not see how this program would address the issues of wellness and prevention; they thought this would only address a person's needs when he or she reached a point at which he or she was going to the emergency room to obtain health care.

*"It seems the persons is sick when they go to get care. This plan does not address keeping someone healthy, like wellness-type stuff." Consumers with Health Insurance, Bennington*

Participants were extremely skeptical that doctors and hospitals would participate in plans that would require them to provide free or subsidized health care. They did not believe in the willingness of health care providers to *"give away"* their services. Even when told that providers are reimbursed for some services, participants did not believe many providers would be willing to participate in the Direct Care Model option.

*"I am just trying to figure out how you're going to get providers to buy into this as far as the sliding scale fee. They've got fixed costs to run their business." Businesses Offering Health Insurance, Burlington*

*"I can't see the doctors getting involved with that, honestly." Businesses Not Offering Health Insurance, Rutland*

Participants stated their belief that there is no such thing as a "free lunch," meaning they do not believe that anyone would simply give away care. Participants insisted that someone, somewhere, somehow would end up paying for the care given under this program.

*"Someone has got to pay for this stuff." Consumers with Health Insurance, Bennington*

*"Let's face it, there is not anything in the world that is free. Somebody pays for it." Consumers with Health Insurance, Rutland*

Participants believe that the burden for this program will ultimately fall upon the taxpayers, in the form of higher taxes to subsidize the plan, and upon the insured, in the form of higher health insurance premiums due to the cost-shifting of the difference onto those who can afford to pay.

> *"It leaves the burden on those who are paying insurance premiums." Consumers with Health Insurance, Rutland*

> *"Free health care will most generally result in an increased burden for that part of the population that does try to pay for their own health care." Consumers with Health Insurance, Rutland*

Many questions were raised about the Direct Care Model. Most groups questioned how doctors, who are already overbooked and overworked, would be able to fit in all the new patients who would come to their offices through such a plan. It was noted that many doctors are not taking new patients, even those who have health insurance, because they are too busy with their existing patients.

> *"How are these doctors, if these are not regular patients, how are these doctors going to fit these people in?" Consumers with Health Insurance, Bennington*

> *"It is so difficult to get an appointment with so many doctors as it is. It does not seem realistic that they will take on non-paying patients." Consumers with Health Insurance, Bennington*

Respondents also believe that many doctors currently refuse to take on Medicare and Medicaid patients, because of the low reimbursement rate they receive for the services administered to patients with such insurance. Given this, they assume that doctors would be reluctant to take on even more patients who would not be paying full cost for services. Many participants wanted to know what the reimbursement rates would be for doctors under the Direct Care Model.

> *"The physicians have to put a cap on how many Medicaid patients they can take." Consumers with Health Insurance, Bennington*

> *"I know now that doctors don't want to take people with state coverage because they get reimbursed so poorly." Businesses Not Offering Health Insurance, Rutland*

Other questions regarding the Direct Care Model included questions about exactly how much care such a plan would provide. Would this allow persons to make appointments as often as they liked? Would it cover expensive surgeries, if they were necessary? Participants also questioned how this plan would work if there were no doctors in a particular area who would participate.

Finally, there were questions about who would be doing the case management mentioned in the description. Participants were afraid that the case management would be run by the government or by out-of-state people who would not be personally involved with the people receiving care.

*"Who is the case manager? Is it somebody out of state who does not know the patient personally and who is making decisions arbitrarily?" Consumers with Health Insurance, Rutland*

Again, participants emphasized that this policy option, like the others, does not help everyone in the state find more affordable health insurance. Participants think that this is a program targeted toward people who are most likely already eligible for some type of subsidized care from the state. Participants mentioned that they are concerned that this option would result in people having to wait a long time to obtain medical care.

Other drawbacks cited by participants included the lack of prescription drug coverage in the Direct Care Model. Participants noted that although this plan may get people access to health care, it does not address the need for affordable prescription drugs or drug coverage.

*"The other thing is medication. If the person gets to see the doctor, then can't afford to buy the pill, what is the point?" Consumers with Health Insurance, Rutland*

A few participants believe that such a plan would need to be accompanied by an educational campaign to inform people about eligibility requirements and to explain how a sliding scale fee-for-service plan would work.

Despite all the questions and confusion over the Direct Care Model, participants did praise the Direct Care Model for getting people access to health care. It is widely agree that, if such a plan worked, it would reduce the costs of caring for the uninsured by reducing the number of emergency room visits for non-emergencies and by integrating the uninsured into mainstream medical care where they would have access to preventive care.

*"[A benefit is] that uninsured people can get some health care. Some preventative care, not just crisis care." Consumers with Health Insurance, Bennington*

*"When people walk into an emergency room for something that should be taken care of in a doctor's office, it is much more expensive to the state." Businesses Not Offering Health Insurance, Rutland*

*"A major selling point of this thing is to introduce people to more formalized health care systems than in the past." Businesses Offering Health Insurance, Burlington*

According to participants, another benefit of this plan is the sliding scale feature, where the uninsured are asked to share the cost burden based on their ability to pay.

*"I think it is good because people have to pay on a sliding scale. It encourages them to take a little more responsibility." Businesses Not Offering Health Insurance, Rutland*

A few participants felt that if such services were available, some individuals would drop their insurance coverage and participate in the Direct Care Model instead. In fact, a few participants

were very interested in doing just that. They indicated they would prefer to pay only for services they used rather than pay a monthly premium *"just in case"* they ever needed medical care.

> *"The model is kind of appealing. I would [like] to see what the direct payment schedule would be versus what I am paying now, with premiums and deductibles and everything else." Businesses Offering Health Insurance, Bennington*

## E. Medicaid Eligibility Expansion

This policy option was described as one that would increase the income eligibility levels for VHAP to 300% of the federal poverty level (FPL) for all Vermont residents. The description noted that, since children whose parents earn up to 300% of FPL already qualify for Dr. Dynasaur, this plan would primarily affect adult Vermonters. (See Appendix II for full plan description.)

Participants had very mixed reactions to this plan. Before getting into specific details of the policy option and specifics about eligibility, most participants agreed that they would support the state of Vermont expanding income eligibility for state-sponsored health insurance. However, participants tended to get bogged down in the specifics of household size, percent of federal poverty level and corresponding income levels for qualifications.

Many participants wanted to discuss their perceptions of VHAP eligibility requirements. A few participants listed requirements – such as the belief that if you own a car you are not eligible and that if you dropped employer-sponsored coverage because you could not afford it, you would not be eligible for VHAP for 12 months – that they felt were unfair. Participants indicated that these other requirements made the policy option seem misleading, because it appeared to be based on household income as the only requirement.

Many participants indicated that the Medicaid Eligibility Expansion is a good idea, targeted toward the best audience, individuals rather than employers. They see that this policy option would achieve the goal of insuring more people, specifically addressing the needs of uninsured adults in Vermont.

> *"I think it is a good idea." "This is on an individual basis. I think you can get so much more done on an individual basis, as opposed to through an employer." Businesses Offering Health Insurance, Burlington*

> *"More people would be insured." Consumers with Health Insurance, Bennington*

> *"The benefits of this plan are simply that it would reach out to a lot of people." "It seems earmarked to those who need it most." Consumers with Health Insurance, Rutland*

This plan is seen as the one that would best address the needs of individuals who hold several part-time jobs, or those who have seasonal work, and are not offered health insurance by their employer(s).

*"This plan would be good for people who hold several jobs, which is very much the case in Vermont." Businesses Offering Health Insurance, Bennington*

The result of expanding eligibility and covering more Vermonters would be healthier citizens, according to participants. It is believed that people would be more likely to get preventive care, and would be less likely to wait until a health condition deteriorated and became an emergency to seek treatment. Overall, respondents thought that this plan would reduce expenses because people would not use emergency rooms as often.

*"People don't seek treatment because they do not have coverage. This would make a healthier, more productive society." Consumers with Health Insurance, Bennington*

As with the other plans, participants disliked some of the eligibility requirements. Some participants felt that 300% of the federal poverty level was too high an income to qualify for government assistance.

*"A family of four? $53,000? That seems to be a decent salary for a family to qualify for care." "I would say [300% FPL] seems extremely high. There are a lot of people working and the reason they are working is for health insurance. At $25,000 that person is making $12, $13 an hour. Why can't they afford something at that wage?" Consumers with Health Insurance, Bennington*

However, most respondents disagree, indicating that 300% of the federal poverty level is not a large enough expansion, that even more people should be eligible to participate in VHAP. Some stated the belief that everyone should be treated the same – regardless of their income or whether they have children. For some this meant that income should not be a factor, that every Vermonter who wished to be covered by a state health plan should be eligible. For others it meant that income levels for participation should not vary depending on parental status. For others it meant that the proposed expansion should occur at the same time for everyone.

*"As a single person, $25,000 is before taxes and all that. Then you've got your mortgage and all your insurances. $25,000 is not a lot of money." Consumers with Health Insurance, Bennington*

*"They should start at 200% of FPL for everybody, not just the ones with children." Consumers with Health Insurance, Bennington*

A few participants noted that many people are not aware of what the eligibility levels are now to qualify for state assistance. These participants believe VHAP and other programs need to be better publicized.

*"I think that some of the problem is programs are not advertised for people. I don't think people are told about it." Consumers with Health Insurance, Bennington*

One issue which raised many questions in the minds of participants is how this plan would affect employer-sponsored health insurance. Employers wondered if this would mean that employees

would drop out of their plans, making it more difficult for employers to meet participation requirements. Others welcomed the possibility that they would be responsible for insuring fewer employees. Some even saw the opportunity to drop employer-sponsored coverage altogether, because their employees would be covered by the state.

> *"Does that mean that people will drop out of private sector insurance?" Businesses Offering Health Insurance, Burlington*

> *"The big benefit here is that employers don't have to pay for coverage, because it will be accessible through government funding. So, for those people who fall into these wage levels who have to pay into an employer plan . . . they will now be able to opt out of the employer plan." "Which has ramifications for the employer because you are supposed to have a certain percentage of your employees covered by your plan." Businesses Offering Health Insurance, Bennington*

> *"This would take the responsibility off the employer, wouldn't it?" Businesses Not Offering Health Insurance, Rutland*

One of the drawbacks cited in every focus group is the belief that this policy option will end up costing taxpayers more money. Participants were particularly concerned that implementation of this plan would result in higher taxes.

> *"Does this mean that the state income tax level will rise?" Consumers with Health Insurance, Bennington*

> *"It is going to increase our taxes." Businesses Offering Health Insurance, Burlington*

> *"How much is it going to cost us in additional taxes?" Businesses Not Offering Health Insurance, Rutland*

Although many respondents believe that taxpayers would foot the bill for this policy option, some recognize that taxpayers today end up covering the cost of treatment of the uninsured in emergency rooms and free care clinics subsidized with tax dollars.

> *"I think this plan would help a lot of uninsured people now, but we will all have to pay for it in our taxes – state and federal." "Yes, we are going to pay for it in the end, but we are going to pay for it anyway." Businesses Not Offering Health Insurance, Newport*

Only one focus group mentioned that increasing the number of people covered under Medicaid would increase the amount of the cost shifting that occurs as a result of low reimbursement rates.

> *"The more people that get on [VHAP], the less the doctor is going to get paid. The higher the doctor's costs are going to go for other people." "We are paying taxes, plus, those of us who do have coverage, we are going to have to pay higher doctors' fees." Businesses Not Offering Health Insurance, Rutland*

Another drawback participants point out in this policy option is that there are no provisions that allow individuals to gradually move from government assistance to private health insurance. Participants indicate they would like to see an income "taper" rather than a "cap" or a "cutoff." Participants think that VHAP should introduce premium payments, co-pays and deductibles, so that people who make over 300% FPL could continue to participate, but pay their fair share of the costs.

> *"[This plan] does not address the option of paying premiums on a sliding scale. It cuts off and that is it. If you're making $100 more, you are not eligible." Consumers with Health Insurance, Bennington*

> *"Would it be a good idea to give the family that makes $55,000 the option of paying in something so that they can still get assistance from VHAP, but it recognizes that they are making a little more money?" Consumers with Health Insurance, Bennington*

> *"Why don't they do something like, say, you make a little more [than the cap] so you will pay $200 a month. She might get it for free, I might pay $300 a month, he might pay $100 a month." Businesses Not Offering Health Insurance, Newport*

As with other policy options, respondents also note that, ultimately, expanding Medicaid eligibility does not address what they perceive to be the major issues: reducing the costs of health care and having affordable health insurance policies available in the state of Vermont.

> *"I feel that we are not addressing affordable health care. We are really not addressing the problem." Consumers with Health Insurance, Rutland*

## III. REACTIONS TO POLICY OPTIONS AMONG CONSUMERS WITHOUT HEALTH INSURANCE

As mentioned in the report Overview, the findings for the focus groups with consumers without health insurance were not available for inclusion in the analysis of the other six groups. Therefore, the findings from the focus groups of consumers without health insurance are presented in this section.

In the groups conducted with consumers without health insurance, three plans were discussed in-depth: Medicaid Eligibility Expansion, the Direct Care Model and the VHAP Buy-In to Employer-Sponsored Health Plans. The Employer Health Insurance Tax Credit and the Low-Cost Insurance Plan were also briefly discussed.

As with the other groups, the consumers without health insurance found the policy options difficult to digest and understand. Again, much of the time during the groups was spent describing and explaining different elements of the plans, rather than discussing the merits and drawbacks. However, the uninsured groups did seem to have a clearer grasp of some of the concepts discussed, specifically the Direct Care Model and the policies involving VHAP or Dr. Dynasaur. This is most likely because these groups are more familiar with the services than participants in other groups.

These participants also personalized their evaluations of the policy options. Often they indicated their preferences for policies in terms of how beneficial the policy would be for their individual situation.

## A. Direct Care Model

This policy option was described as one that would expand the availability of free or subsidized health care for the uninsured. It was described as a plan that would allow the uninsured to obtain medical care at a physician's office and would require some participants to pay for a portion of services based on a sliding fee scale. (See Appendix II for the full plan description.)

Consumers without health insurance are less confused about how the direct care model would work than other groups. However, these participants did find parts of the description confusing and had many questions about how this policy option would work.

Participants were confused about the hospital as the intake point for getting uninsured Vermonters integrated into this model. Participants thought this would mean that individuals would have to go to the hospital or emergency room each time they wanted to see the doctor or that the uninsured would be denied care at emergency rooms and be told to see a physician during regular business hours.

> *"If there is a way to see a doctor without going to the hospital first, that would be good." Consumers without Health Insurance, Middlebury*

> *"What happens if you need to go during the night? You can't go [for care] because it is not regular business hours?" Consumers without Health Insurance, Middlebury*

Participants suggested that there be other ways of getting the uninsured involved in the Direct Care Model, such as intake points at clinics, or an office that the uninsured could call or visit to apply for the program. Participants were particularly concerned that hospital staff would not have the time to properly screen individuals, process applications and distribute information on the program.

> *"Maybe apply over the phone or by mail or something like that besides having to go to the hospital each time." Consumer without Health Insurance, Burlington*

> *"If you go to the ER and they are doing all this . . . screening you, they need to know all your information, your income and the whole works, that would take too much time." Consumers without Health Insurance, Middlebury*

Participants were also confused about the income requirements for participation. Some thought that the sliding scale fee-for-service would apply to those whose household income was *no lower than* $53,000. Some were also confused by this policy option because they did not understand that it is not intended to be a health insurance policy. Some wanted to know if pre-existing conditions would be covered under this plan.

Similar to the other groups, the uninsured participants also questioned whether it is feasible to assume that doctors would participate in such a plan. Participants wanted to know how the doctors would get paid for their services, what the reimbursement rates would be and how doctors could afford to treat people if they were not being fully paid for their services. All in all, there was skepticism about doctors' willingness to participate in the Direct Care Model.

> *"I don't see that as being possible even. It is hard enough to get doctors to do the clinic." Consumers without Health Insurance, Middlebury*

Other questions about this plan were similar to issues raised in other focus groups. Concerns included who the participating doctors would be and what would happen in areas where no physician was willing to participate in such a plan. Would the Direct Care Model require that people have to travel far to obtain medical services from participating providers? What if a participant needed to see a specialist? How does this program address the cost of prescription drugs?

The uninsured raised one slightly different question about this policy option. They were concerned about the amount of paperwork that would be involved in participating in the program and how long it would take to get people integrated into the system.

> *"Lots of times it can be months (when paperwork is involved) because they say they can't see you until they have verification of your income. You need to get that from the state and that is a pretty big process." Consumers without Health Insurance, Burlington*

However, despite their questions about the option, participants were generally very favorable toward the concept. They particularly liked the idea of being able to pay for services on a sliding scale fee-for-service basis.

> *"It is definitely seeking to provide more care for people who don't have the income." Consumers without Health Insurance, Burlington*

> *"The sliding scale fee is probably the best thing about it. It gives everybody an option to be able to get access to some kind of medical care regardless of how much money they have or don't have." Consumers without Health Insurance, Burlington*

> *"I liked that sliding scale. I think that is probably one of the fairest ways to do it. You feel more comfortable about paying. At least you are doing your share of what is fair. You don't want it for free, you like to pay what you can." Consumers without Health Insurance, Middlebury*

Participants in Middlebury indicated that a variation of this model exists now. They also note that they believe it is just not publicized well enough. They state that the existing program is not widely known about nor is information offered up to patients.

*"Publicity is another issue. This is about services that are already offered. The fact is a sliding scale does already exist. However, you are required to seek it out." Consumers without Health Insurance, Middlebury*

## B. Medicaid Eligibility Expansion

This policy option was described as one that would increase the income eligibility levels for VHAP to 300% of the federal poverty level (FPL) for all Vermont residents. The description noted that, since children whose parents earn up to 300% of FPL already qualify for Dr. Dynasaur, this plan would primarily affect adult Vermonters. (See Appendix II for full plan description.)

Overall, consumers without health insurance are favorable toward the idea of expanding Medicaid eligibility. Many participants believe that this plan will directly benefit more people than the other plans. Additionally, they see that Medicaid Eligibility Expansion is targeted toward the groups who need the most help – families with kids and low-income Vermonters. Participants also liked the idea that, rather than instituting a new program, this policy option builds on programs already in place.

*"I'm in favor of raising it. I'm sure everybody is. Because that is the reason I do not have it. I had it, then I lost it because I went to a better paying position. In order to get that little better job, I had to lose my insurance." Consumers without Health Insurance, Middlebury*

*"I think this [policy option] is more inclusive." "I think one advantage is that this builds on a program that is already in progress." Consumers without Health Insurance, Burlington*

However, like other focus groups, some of the uninsured participants did not like the idea of a gradual expansion of the program. Some felt that individuals without children should not have to wait for their expansion to begin, others questioned why the FPL eligibility requirements should be different for those with children and those without. Overall, participants agree that help is needed for all Vermonters, sooner rather than later.

*"We need the plan as soon as possible." Consumers without Health Insurance, Middlebury*

*"I think the expansion part needs to be a little bit broader. [There are people who get] left outside until [the eligibility level] is increased for them. If you are going to do it, you should do it for everybody. Maybe you don't go as high on the FPL, go up gradually there, but raise it for all groups at the same time." Consumers without Health Insurance, Middlebury*

As one of the earlier focus groups mentioned, uninsured Vermonters express concern about the expansion of eligibility and the reimbursement rates for doctors. Participants note that, because reimbursement rates are low, doctors will not be willing to take on new VHAP patients. A few participants mention that an expansion of eligibility should be accompanied by an increase in the reimbursement rates.

> *"A lot of doctors no longer take VHAP because the state will only reimburse them 65%, and they lose money every time they take a patient. So if there are more people on VHAP, there are going to be more doctors getting only 65%. It is coming down to the doctors and whoever else is doing it. If it is state funded they should give them enough money where they can do that and still maintain a practice." Consumers without Health Insurance, Burlington*

As mentioned in other groups, the consumers without health insurance would also like to see VHAP adopt a sliding scale policy for participants at the upper-limits of the income eligibility scale. Respondents suggested allowing VHAP participants "*ease-off*" the plan, by paying premiums, co-pays and deductibles in accordance with their income. This would allow VHAP participants to accept raises and/or higher paying jobs without losing their health insurance. For some it would also allow participants who do not have access to health insurance to participate.

> *"There should be a soft outer limit for where income eligibility ends because people want to take that job and earn a little more money, but don't want to be penalized by losing all the benefits." Consumers without Health Insurance, Middlebury*

In both focus groups with uninsured Vermonters, participants mentioned concerns about the amount of "*red tape*" and paperwork required for enrolling in VHAP. Participants in both groups also mentioned that they had heard that the state was planning to discontinue the VHAP program this coming October.

## C. VHAP Buy-In to Employer-Sponsored Plans

Consumers without health insurance had very similar reactions to the VHAP Buy-In policy options as did participants in other groups. Initially, they liked the idea, however they expressed significant concern over the differences in benefits between Dr. Dynasaur and employer-sponsored plans. They were also concerned about the possibility that parents would not be able to choose whether to keep their children on Dr. Dynasaur or move them to a private plan.

Participants liked the idea that families would be covered under one plan and they felt that covering a spouse at no additional charge was a great benefit of this policy option. Most agree that the VHAP Buy-In would only be an acceptable policy option if the private insurer offered a similar level of benefit for the insured.

*"I guess it would depend on the plan that employers were providing. . . if the coverage that you received would provide the same amount of benefits for the children as they receive under Dr. Dynasaur." Consumers without Health Insurance, Burlington*

*"If this costs the state less money with the same coverage, fine." Consumers without Health Insurance, Middlebury*

Both groups of uninsured Vermonters expressed concern that, under this policy option, the state would *"force"* people to purchase individual plans, even if a parent currently chooses not to be insured. Participants asked whether children would be denied coverage under Dr. Dynasaur if one of their parents had access to employer-sponsored health insurance, but choose not to enroll in the plan. It was noted that many people who have their children on Dr. Dynasaur, choose not to accept employer-sponsored health insurance because of the cost.

*"This would be okay if it were optional. But if a parent can't afford the payment for individual insurance, their kid should still be able to get Dr. Dynasaur separately." Consumer without Health Insurance, Burlington*

*"It sounds like a good plan where you get more for your money. But what if you are a family that can't afford the single insurance in the first place? Does that leave your kids without Dr. Danseur?" Consumers without Health Insurance, Burlington*

*"I know a lot of people that don't have health insurance because they can't afford the payment. If it is the difference between your electric bill, phone bill, rent or health insurance, insurance is going to go out of the window. And if they are telling you that you have to pay for insurance in order for your kids to get it, then kids are going to be left out." Consumers without Health Insurance, Burlington*

Others mention that a parent may choose not to accept an employer-sponsored plan because of the quality of the coverage being offered or because they do not want to do business with that insurer.

*"What if people are dissatisfied with their employer's choice of health insurer?" Consumers without Health Insurance, Middlebury*

Participants wondered what effect this policy option would have on employers. However, in one group, participants thought this plan would be beneficial to employers, allowing them to have more insured persons in their group and, therefore, to be able to bargain for better rates.

*"This would probably encourage more employees to take out the extra family plan, since they are going to get help. That, in turn will help the employer because the more people he insures, the cheaper the policies are." Consumers without Health Insurance, Middlebury*

Similar to participants in other groups, participants were concerned about what would happen to children whose parents did not have access to employer-sponsored insurance. Would they be

uninsured? Others questioned what would happen if a parent chose to take advantage of this policy and then was laid off. Would it be difficult for them to get their children re-enrolled in Dr. Dynasaur?

Overall, participants agree, with a few reservations, that the VHAP Buy-In to Employer-Sponsored Plans is a good idea. Most agree that people should not be forced to participate. Most also think that coverage under Dr. Dynasaur should be an option for anyone who found themselves laid off from their job or if the costs increased and the family could no longer afford their contribution to the employer plan.

## D. Employer Health Insurance Tax Credit

The final two options, the Employer Health Insurance Tax Credit and the Low-Cost Insurance plan were discussed briefly in the uninsured groups. Many of the participants found it difficult to switch gears from evaluating individual-targeted plans to evaluating employer-targeted plans. A number of participants simply found it difficult to evaluate the employer plans because they are not employers.

> *"It is hard to think in terms of being an employer." Consumers without Health Insurance, Burlington*

Generally, participants agreed that the tax credit would be a good plan and would act as an incentive to employers to offer health insurance.

> *"This certainly has incentive for the employer." "It seems like a good plan, because it helps small businesses help to be able to provide health care for their employees, where otherwise they may not." Consumers without Health Insurance, Burlington*

> *"I think they are trying to find a plan that will work for a lot of small employers." Consumers without Health Insurance, Middlebury*

Uninsured participants saw many of the same drawbacks mentioned by participants in other groups. Most agreed that only offering the tax incentive to employers who have not been offering insurance is not fair to those who have been trying to help their employees. Participants also believe that the average wage requirements encourage employers to continue paying low wages so that they can qualify for assistance plans.

> *"Would the company lose this benefit by taking care of their employees (in terms of salary and raises)?" Consumers without Health Insurance, Burlington*

Some participants wanted to know how it would be determined if a company would receive a 25% reimbursement or a 40% reimbursement. One group suggested that the amount of the tax credit be correlated to the company's profitability, so that the least profitable companies would see the greatest benefit from this plan.

*"I would think as a small employer if you are not even turning a profit at the end of the year, then who really cares if the government gives you 25 percent? I would want to see some relationship between what that employer is netting in terms of profit annually and what their reimbursement is." Consumers without Health Insurance, Middlebury*

## E. Low-Cost Insurance Plan

Consumers without health insurance appreciated the Low-Cost Insurance Plan for the fact that the state was offering to help employers afford health insurance and because it would be available to companies with 50 or fewer employers. However, overall, these participants did not feel very positive toward this policy option.

Similar to the other focus group participants, the uninsured participants criticized this policy option because of the benefit exclusions. They found the benefit exclusions to be limiting and, therefore, perceive the plan to be less beneficial to the policy-holder than other commercial plans would be.

*"It is restrictive." Consumers without Health Insurance, Middlebury*

*"It tells more of what it excludes than of what it includes. It seems like it leaves out a lot." Consumers without Health Insurance, Burlington*

Participants also expressed concern about the requirement that half of a company's employees must enroll in the plan. Some wondered if people who can not afford to pay the employee portion of an employer's health insurance plan would be pressured into enrolling in a plan so that the whole company would be eligible.

These participants also mention two other drawbacks to the Low-Cost Insurance Plan that had been mentioned by the other focus groups. First, the uninsured saw that a 15%-20% savings in the cost of the premium is not significant enough of an incentive to get an employer to offer such a plan. Secondly, they thought that the average wage earned requirement would encourage employers to continue to pay low wages.

*"It is not offering nearly enough incentive to the employer. And it is way too restrictive." Consumers without Health Insurance, Middlebury*

*"If they have to keep so many people above or below a certain salary, does that mean we won't get a raise?" Consumers without Health Insurance, Middlebury*

Overall, the consumers without health insurance did not think that the Low-Cost Insurance Plan would be a significant incentive to get an employer to begin to offer health insurance.

*"They way I look at it is, as an employer, I'd be crazy to take this policy." Consumers without Health Insurance, Middlebury*

## IV. COMPARING THE FIVE OPTIONS

### A. Businesses Rate Employer-Targeted Plans

Businesses were asked to rank their choices of the three plans evaluated in depth in the business groups – the two employer-targeted policy options (Employer Health Insurance Tax Credit and Low-Cost Insurance Plan) and the VHAP Buy-In to Employer-Sponsored Plans. Businesses that offer insurance and those that do not offer insurance gave the plans very different rankings.

Generally, participants from businesses not currently offering employees health insurance choose the Employer Health Insurance Tax Credit as their first choice and the Low-Cost Insurance Plan as their second choice. Most choose the VHAP Buy-In as their third choice.

The Employer Health Insurance Tax Credit was chosen as first by most participants in the focus groups of businesses not offering insurance primarily because they saw this as the plan that would bring them the most direct benefit. As the plan that most directly benefits employers, participants think that it would be the plan that would encourage most employers to offer health insurance to employees.

> *"I think it has more flexibility than the other ones. It would encourage more employers to offer it." Businesses Not Offering Health Insurance, Rutland*

> *"I just thought it would be a real good thing for somebody like myself to get a credit." "It is money in my pocket, a return on my investment." Businesses Not Offering Health Insurance, Newport*

> *"I want to be able to offer my employees health care, but I can't afford it. So that would help me to be able to afford it." Businesses Not Offering Health Insurance, Newport*

A few of these participants noted they would like to see a combination of the Employer Health Insurance Tax Credit and the Low-Cost Insurance Plan. They feel that the two policy options together would allow employers to begin offering health insurance.

> *"You need the tax credit to go out and find a low-cost plan." Businesses Not Offering Health Insurance, Newport*

Those businesses not offering health insurance who chose the Low-Cost Insurance Plan as their first choice noted that this plan addressed what they feel is the core issue – the high cost of health insurance premiums. To many, reducing the cost of premiums is the first step toward getting more people covered. For others, the Low-Cost Plan would simply allow more employers to afford health insurance, thereby covering more people.

> *"We've got to get the price down first. The tax credit does not mean anything unless you are buying a policy." Businesses Not Offering Health Insurance, Newport*

*"If you are looking to insure the uninsured, I think this would help the most people." Businesses Not Offering Health Insurance, Rutland*

Very few businesses that are not offering health insurance named the VHAP Buy-In to Employer-Sponsored Plans as their first choice. Primarily, those who did choose this option gave one of two reasons: the cost of benefit payments remains the responsibility of private insurers (lessening government's responsibility) and the plan would get employees more involved with their company.

Among employers who are offering health insurance to employees, most named the VHAP Buy-In to Employer-Sponsored Plans as their first choice. Their second choice is the Employer Health Insurance Tax Credit. Among employers already offering insurance, the Low-Cost Insurance Plan is the third choice. Employers offering health insurance point out that these plans are not really geared toward them and would not help them with their insurance struggles.

*"None of these plans address helping an employer who is now trying to provide coverage." Businesses Offering Health Insurance, Burlington*

One of the main reasons employers who offer health insurance choose the VHAP Buy-In policy option first is that they feel it is the best of the three. However, many employers note that they really do not prefer any of the three plans.

*"[I chose the Buy-In first but] I did not think it was the best. I was completely against the other two, so [I chose this one]." Businesses Offering Health Insurance, Bennington*

*"I still don't like it. I don't like any of them. This was least objectionable." Businesses Offering Health Insurance, Bennington*

Other reasons given for naming the VHAP Buy-In as the first choice were that it would achieve the goal of insuring more Vermonters, and would do so without unduly burdening the state or the taxpayers. A few mentioned they liked this plan because it utilizes tools that are already in place and makes them work together more.

*"I think it may get more people insured, more families insured." Businesses Offering Health Insurance, Burlington*

*"Maybe it can help expand coverage without being a huge burden to anybody." Businesses Offering Health Insurance, Bennington*

The Employer Health Insurance Tax Credit was chosen by participants who believed that it would be an incentive to employers who do not currently offer health insurance. As with the employers not offering insurance, those who do offer it saw that the tax credit would provide the most direct benefit to an employer. A few thought that this option contained the least state *"interference"* in health care and business.

*"I just think it offered the best incentive for the employer to go ahead and offer it." Businesses Offering Health Insurance, Bennington*

Very few chose the Low-Cost Insurance Plan as their favorite option. Those who did choose it mentioned that they felt it was the policy option with the most potential. With a little work, they felt the Low-Cost option had the potential to insure the most people.

Overall comments about all three plans evaluated in depth by employers revealed that none of the policy options was overwhelmingly favored. Employers who currently offer health insurance expressed frustration that most plans were targeted toward those not offering plans. Employers who are not offering plans expressed frustration that the plans were targeted toward companies with low-wage-earning employees. Both groups felt that the plans did not address the issue of affordable health insurance for all Vermonters.

*"We still have not solved anything about price itself." Businesses Not Offering Health Insurance, Newport*

However, most agree that *"something is better than nothing,"* and that these plans do help people without health insurance gain some access to health care.

*"They all at least offer some form of insurance to somebody that has nothing." Businesses Offering Health Insurance, Burlington*

## B. Consumers Rate Individual-Targeted Plans

Consumers were also asked to rank their choices of the three plans they evaluated in depth – the two consumer-targeted policy options (Medicaid Eligibility Expansion and the Direct Care Model) and the VHAP Buy-In to Employer-Sponsored Plans. Participants who have health insurance in Bennington gave very different rankings than did the participants in Rutland. Consumers without health insurance gave different rankings than those with health insurance.

In Rutland, virtually all of the participants with health insurance chose the VHAP Buy-In as their first choice; participants were equally split between Medicaid Eligibility Expansion and the Direct Care Model for second and third place. In Bennington, Medicaid Eligibility Expansion was clearly the first choice, with the Direct Care Model and VHAP Buy-In vying for second and third place.

The VHAP Buy-In was selected as a first choice mostly because those in Rutland found it to be the most credible of the three plans. They liked the idea that the plan lent a helping hand to working Vermonters and it took responsibility for health insurance away from the state. Participants also liked the idea that it would reduce overall costs for the government.

*"It seemed to be the only one that offered any idea that would lessen the tax burden, a little bit anyway." "Re-routing tax dollars is a better use of that money." Consumers with Health Insurance, Rutland*

Bennington participants with health insurance felt that the Medicaid Eligibility Expansion program would cover the most people and had the fewest drawbacks of the three plans considered in depth. Some thought that the Direct Care Model would have the most benefit for the uninsured and those who do not have access to health insurance.

Consumers without health insurance ranked the Direct Care Model and the Medicaid Eligibility Expansion highest of the three plans. Both of the plans were ranked highest because they were perceived to offer the most benefit to the most people. The VHAP Buy-In was ranked lowest of all three plans.

> *"[Medicaid Eligibility Expansion] had something for everyone, more than the other programs. It did more for more people.." Consumers without Health Insurance, Burlington*

> *"[The Direct Care Model] is the one that best suits me in my situation." Consumers without Health Insurance, Middlebury*

Similar to the business participants, consumers who have health insurance noted that none of the plans discussed address the issue of affordable health care and health insurance for all Vermonters.

> *"I don't see how any one of these three plans is really addressing the issue of affordable health care." Consumers with Health Insurance, Rutland*

## C. Support for Each Plan

Near the end of each group, respondents were asked to vote on all five plans that had been presented and discussed. They were asked to vote whether they would support each plan separately, based on the "spirit" of the plan, rather than the exact terms used to describe it.

Two out of three focus group participants indicated they would support the Employer Health Insurance Tax Credit and the Medicaid Eligibility Expansion. Half of those who participated support the idea of the VHAP Buy-In to Employer-Sponsored Health Insurance Plans or the Direct Care Model. About one in three supported the creation of a Low-Cost Insurance Plan.

There were slight differences in support among the different groups of participants. Employers who do not offer health insurance are most likely to support the programs targeted toward employers not currently offering insurance (Employer Health Insurance Tax Credit and Low-Cost Insurance Plan). Employers who do currently offer health insurance prefer the individual-targeted plans (Direct Care Model and Medicaid Eligibility Expansion). Interestingly, the consumers who have health insurance spread their support among the Employer Health Insurance Tax Credit, the VHAP Buy-In and the Medicaid Eligibility Expansion. Consumers who do not have health insurance supported all the plans, except the Low-Cost Insurance Plan.

## V. CONCLUSION

As mentioned in the previous section, focus group respondents felt most favorable toward the idea of tax credits for employers who offer health insurance and expanding the income eligibility levels for the state's Medicaid program.

For the most part, these two programs were favored because participants envision those being the policies that would have the most direct benefit to them. Often during the groups, participants related each policy option to their personal situation, rather than evaluating the options in terms of which would be most beneficial to achieving the goal of insuring more Vermonters. One of the reasons the Low-Cost Insurance Plan was widely criticized was that participants themselves would not like to be covered under a plan with limited benefits.

Personalization of health insurance was an issue that contributed to the difficulty that many participants had in evaluating the policies. When evaluating the plan, participants often experienced significant confusion over the details of the plan. A large part of the time spent discussing each policy option was spent explaining details and clearing up misconceptions based on participants' reading of the policy. Often participants did not see how a particular plan would relate to their personal situation, and, therefore, did not know how to react to the plan. Frequently, respondents were able to step back and evaluate the options based on broader considerations, but it is important to note that they are also evaluating the plans based on their personal situations.

Participants' confusion over the policy options points to a need for better education regarding health insurance in the state of Vermont. From a lack of awareness about current eligibility levels for state programs to misconceptions about provider competition, clearly both employers and consumers do not have as much information as they would like or as they need to make informed decisions about the policy options.

Although focus group participants discussed and evaluated the policy options they were presented with, many did not feel that any of the plans addressed the core issue at stake: affordable health insurance and affordable health care for all Vermonters.

No matter which plan was discussed, participants pointed out that the plan did not address the needs of all Vermonters. It was clear that participants did not like the idea of targeted assistance. Some participants clearly wanted to discuss the concept of a single-payer insurance system for Vermont; others wanted to discuss deregulation of the state's insurance industry. Both felt that such discussions would better address the core issues and would help all Vermonters, not just specific segments of the population.

**Protocol Available Upon Request**

# Appendix H:
# Options to Expand Health Insurance Coverage in Vermont

The Lewin Group

# Options to Expand Health Insurance Coverage in Vermont: Revised to Reflect the 2000 Vermont Survey Project Results

**Presented to:**
**Health Access Oversight Committee**

**By:**
**The Lewin Group, Inc.**

**September 20, 2001**

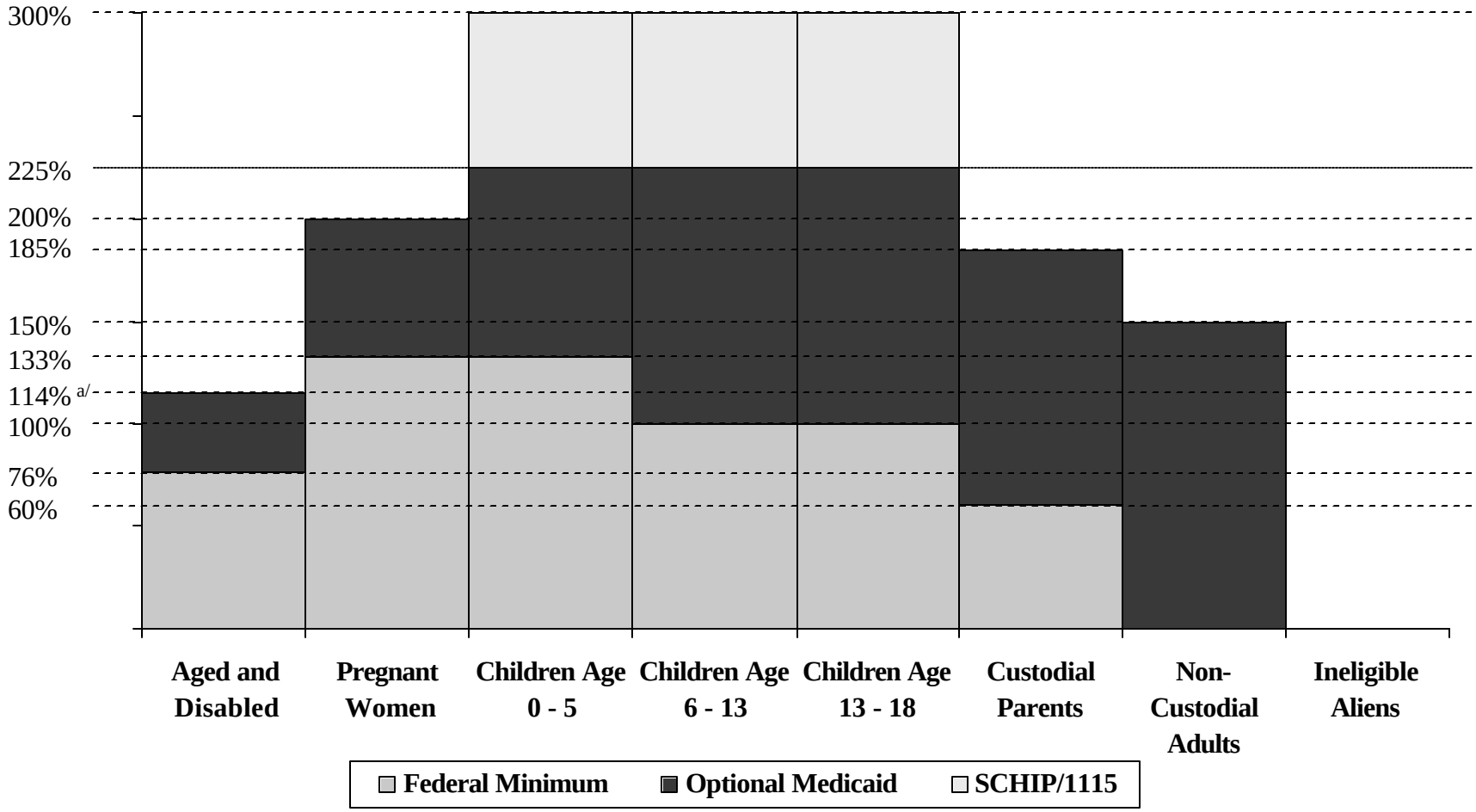
# Options to Expand Insurance

The Lewin Group

- **Income eligibility coverage expansion under Medicaid/SCHIP**
- **Employer coverage buy in for Medicaid/SCHIP-eligible children**
- **Premium subsidies to low-income persons with non-group insurance**
- **Employer tax credits for small firms with low-income workers**
- **Low-cost coverage options for firms that have not provided insurance in the past 12 months**
- **Single-payer program for Vermont**

# Summary of Income Eligibility Levels as a Percentage of the Poverty Level for Medicaid and SCHIP in Vermont

The Lewin Group




a/ The income eligibility level for aged and disabled persons is equal to 114 percent of the FPL in Chittenden County and 105 percent of the FPL in the rest of the state.

# Estimated Coverage and Cost Impacts of Selected Expansions in the Vermont Medicaid/ SCHIP Program

The Lewin Group

| | Newly Eligible Persons (in thousands) | Newly Enrolled Persons (in thousands) | Newly Insured Enrollees a/ (in thousands) | Benefits Costs (in millions) | Premium Revenues b/ (in millions) | Net Program Cost (in millions) | State Share of Costs (in millions) |
|---|---|---|---|---|---|---|---|
| **Eligibility Level** | | | | | | | |
| **Below 185% FPL** | | | | | | | |
| **Children** | - - | - - | - - | - - | - - | - - | **- -** |
| **Parents** | - - | - - | - - | - - | - - | - - | **- -** |
| **Other Adults** | 10.4 | 4.5 | 4.3 | $9.5 | - - | $9.5 | **$9.5** |
| **Total** | **10.4** | **4.5** | **4.3** | **$9.5** | **- -** | **$9.5** | **$9.5** |
| **Below 225% FPL** | | | | | | | |
| **Children c/** | - - | 0.4 | 0.5 | $0.3 | - - | $0.3 | **$0.1** |
| **Parents** | 8.8 | 1.5 | 0.5 | $2.8 | - - | $2.8 | **$1.0** |
| **Other Adults** | 20.3 | 6.8 | 5.9 | $14.6 | - - | $14.6 | **$14.6** |
| **Total** | **29.1** | **8.7** | **6.9** | **$17.7** | **- -** | **$17.7** | **$15.7** |
| **Below 300% FPL** | | | | | | | |
| **Children c/** | - - | 0.4 | 0.5 | $0.3 | - - | $0.3 | **$0.1** |
| **Parents** | 36.0 | 4.4 | 1.2 | $8.2 | $3.1 | $5.1 | **$1.9** |
| **Other Adults** | 45.9 | 8.6 | 6.6 | $17.4 | $2.0 | $15.4 | **$15.4** |
| **Total** | **81.9** | **13.4** | **8.3** | **$25.9** | **$5.1** | **$20.8** | **$17.4** |

a/ The number of new enrollees who otherwise would been uninsured.
b/ We assume that a premium would be required for persons above 225 percent of the FPL on a sliding scale with income.
c/ We estimate that there would be a small increase in SCHIP enrollment as newly eligible parents become enrolled. These SCHIP-eligible children who have not enrolled under the current program.
Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

# Buy Children Into Parent's Employer Plan if Less Costly

The Lewin Group

- **Cost to state must be less than if children covered under Medicaid/SCHIP**
- **Ineligible parents become covered if automatically covered by family policy**

**Employer Buy-in Program for Vermont**

| | Number Enrolled | Newly Insured | Total Program Costs (in thousands) | State Share (in thousands) |
|---|---|---|---|---|
| **Buy in for Children under Medicaid/SCHIP** | 823 | 355 | ($616) | ($210) |

Source: Lewin Group estimates based upon experience in other states with program.

# Refundable Tax Credit for Persons Purchasing Non-group Coverage

The Lewin Group

- **Eligibility criteria**
  - **Limited to persons with incomes below 300 percent of the Federal Poverty Level (FPL)**
  - **Persons purchasing non-group coverage**
  - **Without access to employer coverage**
- **Tax credit amount**
  - **$750 individuals / $1,500 families**
  - **$1,000 individuals / $2,000 families**
  - **$1,250 individuals / $2,500 families**
- **Tax credit phased out between 225% FPL and 300% FPL**
- **Refundable credit (credit amount can exceed tax liability)**

# Cost and Coverage Impacts of a Tax Credit for Individuals Purchasing Non-group Coverage

The Lewin Group

| | Eligible | Enroll | Newly Covered | Total Cost (in millions) | Cost per Enrollee | Cost per Newly Insured |
|---|---|---|---|---|---|---|
| **$750/$1,500** | | | | | | |
| **Currently Insured** | 26,400 | 22,700 | - - | $13.4 | $595 | |
| **Uninsured** | 20,600 | 6,624 | 6,624 | $3.0 | $658 | |
| **Total** | **47,000** | **29,324** | **6,624** | **$16.4** | **$596** | **$3,417** |
| **$1,000/$2,000** | | | | | | |
| **Currently Insured** | 26,400 | 22,700 | - - | $17.8 | $784 | |
| **Uninsured** | 20,600 | 7,728 | 7,728 | $4.8 | $865 | |
| **Total** | **47,000** | **30,428** | **7,728** | **$22.6** | **$797** | **$4,036** |
| **$1,250/$2,500** | | | | | | |
| **Currently Insured** | 26,400 | 22,700 | - - | $20.9 | $921 | |
| **Uninsured** | 20,600 | 9,522 | 9,522 | $7.1 | $1,029 | |
| **Total** | **47,000** | **32,222** | **9,522** | **$28.0** | **$943** | **$4,058** |

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

# Tax Credit for Small Employers with Low-wage Workers in Vermont

The Lewin Group

- **Tax credit for employer contributions for worker coverage in firms**
  - **With average payroll below the average for small firms in Vermont**
  - **That have not provided coverage in 12 months**
- **Variations of firm eligibility and size of credit**
  - **Firms under 10 workers - 25 percent credit**
  - **Firms under 10 workers - 40 percent credit**
  - **Firms under 25 workers - 25 percent credit**
  - **Firms under 25 workers - 40 percent credit**

# Cost and Coverage Impacts of Tax Credits for Small Employers with Low-wage Workers in Vermont

The Lewin Group

| | Eligible | Enroll | Newly Covered | Total Cost (in millions) | Cost per Enrollee | Cost per Newly Insured |
|---|---|---|---|---|---|---|
| **Under 10 Workers** | | | | | | |
| **25% Credit** | | | | | | |
| **Currently Insured** | 7,200 | 2,100 | - - | $1.0 | $483 | |
| **Uninsured** | 5,500 | 2,484 | 2,484 | $0.9 | $494 | |
| **Total** | **12,700** | **4,584** | **2,484** | **$1.9** | **$487** | **$1,045** |
| **40% Credit** | | | | | | |
| **Currently Insured** | 7,200 | 2,800 | - - | $2.1 | $790 | |
| **Uninsured** | 5,500 | 3,450 | 3,450 | $2.0 | $810 | |
| **Total** | **12,700** | **6,250** | **3,450** | **$4.1** | **$799** | **$1,712** |
| **Under 25 Workers** | | | | | | |
| **25% Credit** | | | | | | |
| **Currently Insured** | 9,300 | 2,700 | - - | $1.2 | $451 | |
| **Uninsured** | 7,200 | 3,312 | 3,312 | $1.1 | $463 | |
| **Total** | **16,500** | **6,012** | **3,312** | **$2.3** | **$457** | **$966** |
| **40% Credit** | | | | | | |
| **Currently Insured** | 9,300 | 3,500 | - - | $2.6 | $742 | |
| **Uninsured** | 7,200 | 4,416 | 4,416 | $2.4 | $761 | |
| **Total** | **16,500** | **7,916** | **4,416** | **$5.0** | **$751** | **$1,588** |

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

# Subsidized Coverage for Small Businesses in Vermont

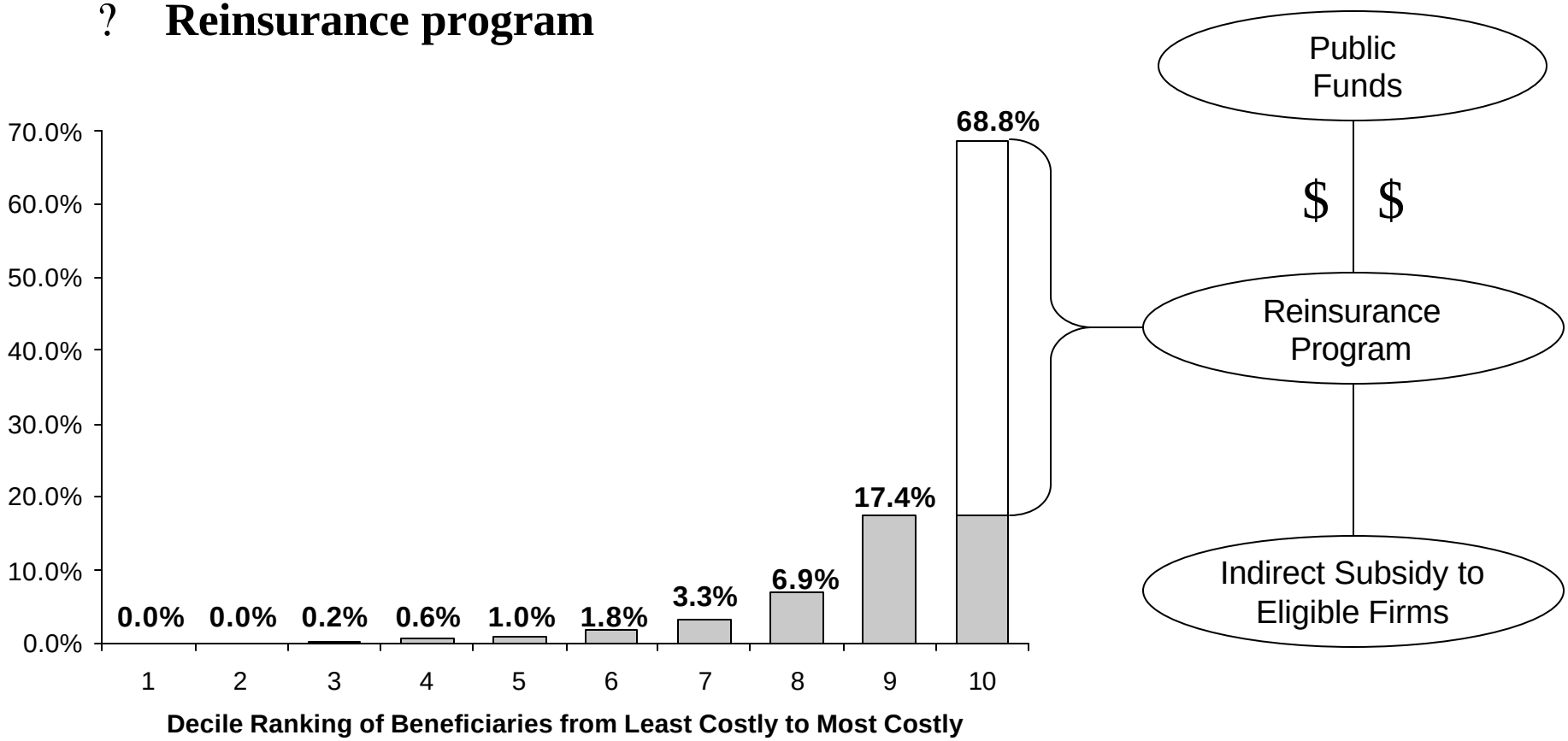
The Lewin Group

- **Eligibility Limited to Firms:**
  - **50 or Fewer Workers With at Least Half Enrolling in Plan**
  - **Have Not Offered Coverage in Prior Year**
  - **Less Than 30 Percent of Workers Earning Over $30,000**
  - **Employer Pays at Least Half of Premium**
- **Insurers May Offer Lower Cost Benefits Package**
  - **Exempt From Benefit Mandates - Chiropractic, Alcohol and Drug, Home Health**
  - **No Mental Health**
  - **$500 Deductible, $100,000 Maximum Per Beneficiary**
- **Reinsurance**
  - **90 Percent of Costs Between $30,000 and $100,000**
  - **State Revenue**
- **Similar Program for Individual Market**
  - **Self-employed and Individuals Below 250% of FPL**
  - **Uninsured for Prior 12 Months**

# Subsidized Insurance for Small Groups Through State-funded Reinsurance

The Lewin Group

- **Exempt from benefits mandates**
- **Reinsurance program**




Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

# Low-cost Coverage Options for Non-insuring Firms with Less than 25 Workers

The Lewin Group

| | Number Enrolled | Newly Insured | State Cost (in thousands) |
|---|---|---|---|
| **Three-year Exemption from Mandatory Benefits Only** | 1,350 | 1,350 | - - |
| **State-funded Reinsurance Only** | 2,700 | 2,700 | $573 |
| **Mandatory Benefits Exemption with State-funded Reinsurance** | 4,050 | 4,050 | $860 |

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

# Single-Payer Model

The Lewin Group

- **State operated program covering all Vermont residents**
- **Benefits package modeled on employer health plans**
  - **Inpatient/outpatient hospital care**
  - **Physician services**
  - **Other health professional services**
  - **Mental health**
  - **Preventive dental and vision exams**
  - **Prescription drugs**
- **Copayment of $10.00 per visit. No deductible.**
- **The program would include a primary care provider referral (i.e., gate keeper) model. Fifty percent copay on specialist visits without referral.**

# Analysis of Program Costs and Revenues under the Vermont Single-payer Proposal in 2001

(in millions)

The Lewin Group

| Uses of Funds | | Sources of Funds | |
|---|---|---|---|
| **Program Expenditures** | | **Inter-Governmental Transfer Revenues** | |
| **Benefit Payments** [a/] | **$1,705.5** | **CHAMPUS/Military** [e/] | **$53.8** |
| **Payment Adjustments** [b/] | **($124.5)** | **Medicare** [f/] | **$363.8** |
| **Uncompensated Care Savings** | ($50.0) | **Medicaid** | **$216.5** |
| **Provider Administration** | ($47.1) | **State Share** [g/] | $82.3 |
| **Managed Care Adjustment** | $2.8 | **Federal Share** [h/] | $134.2 |
| **Prescription Drug Rebate** | ($30.2) | **Other State and Local** | **$0.7** |
| **State and Local Employee Benefits** [c/] | **($59.4)** | **Federal Employee Health Benefits Program** | **$10.1** |
| **Insurance Administration** [d/] | **$35.8** | **TOTAL Government Transfers** | **$644.9** |
| | | **New Tax Revenues** | |
| | | **Payroll Tax (Net of Wage Effect)** [i/, j/] | **$920.2** |
| | | **Employer (5.8%)** | $613.2 |
| | | **Employee (2.9%)** | $307.0 |
| | | **Wage Effects of Payroll Tax** [k/] | **($7.7)** |
| | | **TOTAL Tax Revenues** | **$912.5** |
| **TOTAL Expenses** | **$1,557.4** | **TOTAL Revenues** | **$1,557.4** |

# Analysis of Program Costs and Revenues under the Vermont Single-payer Proposal in 2001

(notes)

The Lewin Group

a/ Includes provider payments for acute care health services that are covered under the program. Provider payments are estimated based upon overall average provider payment levels under current programs. Excludes patient copayments and spending for non-covered services.

b/ We assume that provider payment rates are reduced to reflect reduced uncompensated care expenses and savings in provider administrative costs.

c/ Reflects the net change in state and local employee benefits expenditures as a result of shifting from employer-based health coverage to the payroll tax.

d/ Includes the cost of administering benefits under the single-payer program. Estimates based upon the cost of administering benefits under the Medicare program.

e/ The program will be reimbursed for services provided to persons who are covered under the CHAMPUS program.

f/ Federal Medicare program funding for Vermont residents would be transferred to the Vermont single-payer program. This includes federal funding for Part-A and the federal share of funding for Part-B.

g/ The state share of funding for the Medicaid program is transferred to the single-payer program. Estimates exclude the state share of funding for disproportionate share hospital payments.

h/ The federal share of funding for the Medicaid acute care program would be transferred to the single-payer program. Includes benefits payments, administration and the federal share of disproportionate share hospital payments.

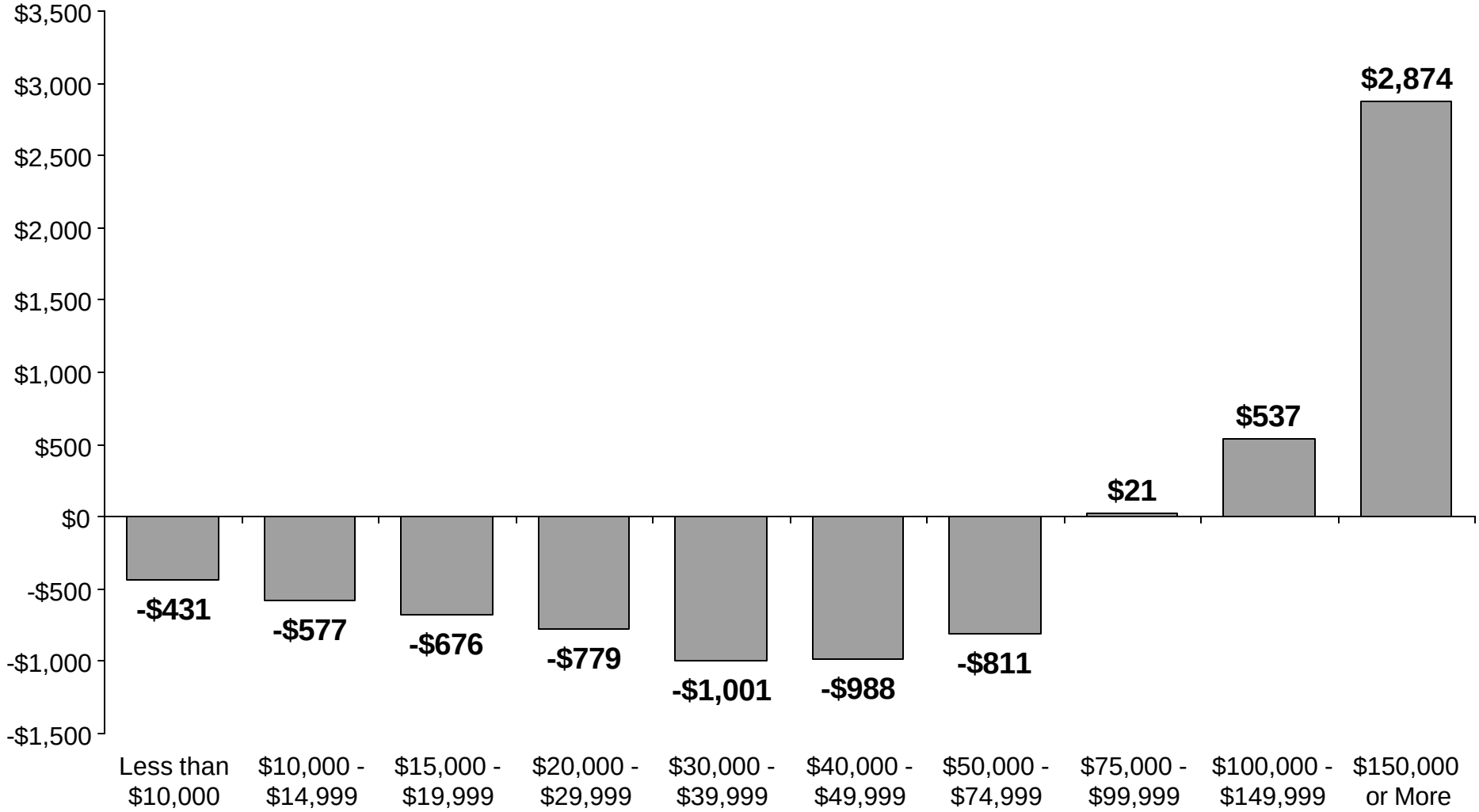
i/ Assumes that the full amount of new funding required for the program would be raised through a payroll tax, which we estimate would be 8.7 percent in 2001. Of this, two-thirds would be paid by employers leaving one-third to be paid by the worker.

j/ A substantial portion of the Vermont population is employed in one of Vermont's bordering states. This creates a funding problem because a state may not impose a tax on employers operating in another state. In this analysis, we assume that all Vermont workers employed outside of the state would be required to pay both the employer and employee shares of the payroll tax. We also assume that these workers would drop their coverage with these out-of-state employers (i.e., eliminate their payroll deductions for the employers current policy, which is made redundant for Vermont workers by the single-payer model). We then assume that these out-of-state employers would voluntarily pay the employer share of the tax for these individuals so that there is no net change in the amount of compensation provided to affected workers.

k/ Assumes that changes in employer costs under the single-payer model would be passed on to workers in the form of lower wages.

Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

# Change in Average Household Health Spending Under the Vermont Single-Payer Model in 2001




Source: Lewin Group estimates using the Vermont version of the Health Benefits Simulation Model (HBSM).

# Summary of Program Costs Under Alternative Single-payer Models in 2002

The Lewin Group

| | With Gatekeeper and $10 Copayment | Without Gatekeeper and No Cost Sharing |
|---|---|---|
| **Single Payer Program Expenditures** | | |
| **Total Program Cost** | $1.5 billion | $1.9 billion |
| **Current Program Funds** | $0.6 billion | $0.6 billion |
| **Payroll Tax Revenue Requirements** | **$0.9 billion** | **$1.3 billion** |
| **Payroll Tax Rates** | | |
| **Employer Share** | 5.8% | 7.5% |
| **Employee Share** | 2.9% | 3.7% |
| **Total** | **8.7%** | **11.2%** |
| **Increase (Decrease) in Employer Spending** | | |
| **Employers that Currently Insure** | $3.6 million | $119.8 million |
| **Non-insuring Firms** | $119.6 million | $154.7 million |
| **Total Employers** | **$123.2 million** | **$274.5 million** |
| **Impact on Total Health Spending** | | |
| **Net Increase (Reduction) in Total Health Spending in Vermont** [a/] | ($118.1) million | $37.7 million |

a/ Includes all health spending across all payers for Vermont residents.

Source: Preliminary estimates developed by The Lewin Group using the Health Benefits Simulation Model (HBSM).

# Summary of Cost and Coverage Impacts for Selected Coverage Expansion Options in Vermont

The Lewin Group

| | Number Enrolled | Reduction in Uninsured Persons | Net New State Costs (in millions) | Percentage of Children Covered | Percentage of Adults Covered | Percentage of Persons Below 300% FPL Who Are Uninsured | Cost Per Enrollee | Cost Per Newly Insured Person |
|---|---|---|---|---|---|---|---|---|
| **Current Coverage** | | | | | | | | |
| **Current Coverage** | - - | - - | - - | 95.8% | 90.2% | 88.9% | - - | - - |
| **Income Eligibility Expansion for Parents under VHAP** | | | | | | | | |
| **Cover Parents Between 185% and 225% of FPL** | 1,500 | 552 | $1.0 | 96.0% | 90.3% | 89.1% | $666 | $1,811 |
| **Cover Parents Between 185% and 300% of FPL** | 4,400 | 1,242 | $1.9 | 96.2% | 90.5% | 89.3% | $432 | $1,530 |
| **Income Eligibility Expansion for Non-custodial Adults under VHAP** | | | | | | | | |
| **Non-custodial Adults Between 150% and 185% of FPL** | 4,500 | 4,278 | $9.5 | 95.8% | 91.1% | 90.2% | $2,111 | $2,220 |
| **Non-custodial Adults Between 150% and 225% of FPL** | 6,800 | 5,934 | $14.6 | 95.8% | 91.5% | 90.7% | $2,147 | $2,451 |
| **Non-custodial Adults Between 150% and 300% of FPL** | 8,600 | 6,624 | $15.4 | 95.8% | 91.6% | 90.9% | $1,790 | $2,325 |
| **Other Medicaid Options** | | | | | | | | |
| **VHAP Buy-in for Employers of Low-Wage Workers and Persons Below 300% of FPL** | 7,668 | 6,503 | $0.0 | 96.2% | 91.5% | 90.4% | $0 | $0 |
| **Expanded Outreach for Children** | 2,457 | 2,457 | $0.5 | 97.5% | 90.2% | 89.7% | $203 | $203 |
| **Buy-in to Employer-Sponsored Coverage for VHAP Children** | 832 | 355 | ($0.2) | 96.0% | 90.2% | 89.1% | ($240) | ($563) |
| **Premium Subsidies for Persons Below 300% of the FPL without Access to Other Coverage (subsidy phase out between 225% and 300% of FPL)** | | | | | | | | |
| **Subsidy of $750 for Individuals, $1,500 for families** | 27,500 | 6,624 | $16.4 | 96.8% | 91.3% | 90.9% | $596 | $2,476 |
| **Subsidy of $1,000 for Individuals, $2,000 for families** | 28,200 | 7,728 | $22.6 | 97.0% | 91.5% | 91.2% | $801 | $2,924 |
| **Subsidy of $1,250 for Individuals, $2,500 for families** | 29,600 | 9,522 | $28.0 | 97.2% | 91.8% | 91.7% | $946 | $2,940 |
| **Employer Tax Credit for Non-insuring Firms (for 12 months) with Average Payroll Below State Average for Small Firms** | | | | | | | | |
| **Firms under 10 Workers: 25 Percent Credit** | 3,900 | 2,484 | $1.9 | 96.2% | 90.6% | 89.4% | $487 | $765 |
| **Firms under 10 Workers: 40 Percent Credit** | 5,500 | 3,450 | $4.1 | 96.3% | 90.8% | 89.6% | $745 | $1,188 |
| **Firms under 25 Workers: 25 Percent Credit** | 5,100 | 3,312 | $2.3 | 96.3% | 90.7% | 89.7% | $451 | $694 |
| **Firms under 25 Workers: 40 Percent Credit** | 6,700 | 4,416 | $5.0 | 96.5% | 90.9% | 90.0% | $746 | $1,132 |
| **Create Low-cost Coverage Options for Non-insuring Firms with Less than 25 Workers (for 12 months)** | | | | | | | | |
| **Three-year Exemption from Mandatory Benefits (assumes 5 percent savings)** | 1,350 | 1,350 | - - | 96.0% | 90.4% | 88.8% | $0 | $0 |
| **Mandatory Benefits Exemption with State-Funded Reinsurance Program (90% coverage for cases Over $25,000)** | 4,050 | 4,050 | $0.9 | 96.4% | 91.0% | 89.5% | $222 | $222 |
| **Single Payer Program** | | | | | | | | |
| **Basic Benefits Model (i.e., copayments with gatekeeper model)** | 609,000 | 51,390 | $0.9 billion | 100.0% | 100.0% | 100.0% | $1,559 | $18,486 |
| **No Cost-sharing Model (i.e., no copayments or gatekeeper program)** | 609,000 | 51,390 | $1.3 billion | 100.0% | 100.0% | 100.0% | $2,167 | $25,685 |

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).