

# Equitable Financing Plan For Vermont's Universal Healthcare System



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Healthcare Is a Human Right Campaign

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# 1. INTRODUCTION

Healthcare financing is a matter of justice and human rights. The system of private, market-based payment for healthcare has caused a deep crisis of inequity that the state of Vermont must address now. The Healthcare Is a Human Right (HCHR) Campaign presents this proposal for equitable, public healthcare financing because we speak for thousands of people affected by this crisis. Too many people cannot use their limited insurance plans to get adequate care, struggle with high out-of-pocket costs and unpaid bills, and have unmet health needs. People's health and wellbeing are on the line.

Market-based health insurance financing is profoundly inequitable: low-income people pay proportionally more for healthcare than the wealthy, while making do with low-value insurance plans.<sup>1</sup> One in five people are struggling with medical bills, while ten BCBSVT executives are paid up to half a million dollars each.<sup>2</sup> This failing system-- with its different and unequal insurance products, different and unequal prices for health services, and different and unequal access to doctors-- costs Vermont a fortune. Healthcare spending is growing faster than the state's GDP, and this trend will continue if we fail to act.<sup>3</sup> We can no longer afford to protect and perpetuate a healthcare system that is both wasteful and unjust.

Vermont is in a prime position to implement a publicly financed healthcare system that guarantees access to care for all, increases equity, and reduces costs. To do so, we do not require new money; we need to share existing payments more equitably. In this report, the HCHR Campaign shows how this can be achieved in Vermont by 2017. We develop an equitable healthcare financing plan that is grounded in Governor Peter Shumlin's proposals for Green Mountain Care and that provides solutions to the questions raised in his report.<sup>4</sup> We present cost and revenue models that demonstrate that it is not only possible, but financially and economically advantageous to implement a publicly financed healthcare system in Vermont.

## HUMAN RIGHTS PRINCIPLES FOR HEALTHCARE FINANCING

The HCHR Campaign has built a people's movement for the human right to healthcare since 2008. Our goal is to realize the human right to healthcare in Vermont by establishing a universal healthcare system that provides healthcare as a public good for all. This system must be guided by the human rights principles of universality, equity, transparency, accountability and participation. We successfully advocated for the incorporation of these principles into Act 48, Vermont's universal healthcare law, passed in 2011.

Act 48 set Vermont on the road to establishing a publicly financed healthcare system, Green Mountain Care (GMC), by 2017. It did not prescribe a financing mechanism but stated that the "financing of health care in Vermont must be sufficient, fair, predictable, transparent, sustainable, and shared equitably."<sup>5</sup>

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<sup>1</sup> Brian Robertson and Mark Noyes, *2014 Vermont Household Health Insurance Survey Initial Findings* (Vermont Department of Financial Regulation Insurance Division, 2014).

<sup>2</sup> Blue Cross Blue Shield of Vermont, *Annual Statement* (Vermont Department of Financial Regulation, 2013).

<sup>3</sup> Al Gobeille, "The Senate Committee on Finance," February 4, 2015,

<http://legislature.vermont.gov/assets/Documents/2016/WorkGroups/Senate%20Finance/Health%20Care/Green%20Mountain%20Care%20Board/W~Al%20Gobeille~Presentation%20to%20Senate%20Finance~2-4-2015.pdf>.

<sup>4</sup> Peter Shumlin et al., *Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Healthcare System*, December 30, 2014.

<sup>5</sup> 18 VSA § 9371, *An Act Relating to a Universal and Unified Health System*, 2011,

<http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=18&Chapter=220&Section=09371>.

In 2012, the HCHR Campaign published a healthcare financing report that analyzed the compatibility of various financing mechanisms and revenue sources with human rights standards.<sup>6</sup> We used the five basic human rights principles to develop detailed financing standards to guide the design of the GMC financing plan. To ensure **universality**, financial resources must follow health needs, and the financing plan has to ensure the sufficiency of funds. To ensure **equity**, financing has to be public, using progressive taxes. Access to care should be free at the point of service. To ensure **accountability, transparency** and **participation**, healthcare financing and administration has to move from the private to the public sector and support people's participation in governance.

Guided by these principles, the HCHR Campaign's 2012 report proposed a progressive income tax, a wealth tax and a graduated payroll tax on employers to finance GMC. We suggested that decision-makers ground their policy choices in the human rights standards, which are reflected in Act 48. Yet when the Governor's plan was finally published on December 30, 2014 - missing Act 48's deadline of January 2013 by almost two years - it was not based on principles. Although the Governor proposed income and payroll taxes for healthcare, these taxes were not designed to function in a sufficiently equitable way. The failure to adequately take into account individuals' and businesses' ability to pay contributed to dooming the Governor's proposals – an unnecessary fate for an otherwise sound plan. Guided by human rights principles, the HCHR Campaign seeks to propose necessary design changes to the Governor's plan, so that it can be used to guide the implementation of GMC.

## HUMAN RIGHTS ASSESSMENT OF THE GOVERNOR'S PROPOSALS

The HCHR Campaign conducted a basic human rights assessment of the Governor's healthcare financing proposals. By flagging issue areas in need of better solutions, this assessment offers a guide for the development of a financing plan that improves and expands on the Governor's proposals.

### Human Rights Assessment of Governor Shumlin's Financing Plan:

#### Universality

- **Populations included:** The Governor's plan is inclusive, though it carves out the Medicare population in the absence of a federal waiver. It offers no Medicare wrap-around for seniors.
- **Health services provided:** The Governor's plan excludes dental, vision, hearing and long-term care.

#### Equity

- **Out-of-pocket costs:** At an actuarial value of 94% GMC greatly improves on commercial plans, but low-income and sick people would still struggle with co-pays. Seniors, in particular, would continue to face high Medicare out-of-pocket costs.
- **Income Tax:** The Governor's income tax proposal is more equitable than private premiums. However, the tax rate rises rather steeply for middle income people, while payments are capped for the wealthy.
- **Payroll Tax:** The Governor's payroll tax is flat, which means businesses' contributions are not based on their ability to pay.

#### Accountability

- **GMC Operations:** The Governor's proposed public utility model for healthcare administration would enable better regulation but also monopolizes the position of a private insurer and guarantees operating surpluses.

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<sup>6</sup> Healthcare is a Human Right Campaign, *Toward Equitable Financing of Green Mountain Care*, December 10, 2012, <http://www.workerscenter.org/sites/default/files/gmcfiancingplan-vwcproposalfinal.pdf>.

- **System costs:** Public oversight and control of healthcare prices is assumed to happen at a future stage, and savings from such rate setting are not explicitly calculated. Rate setting for drug prices, e.g. through price negotiation, is not included at all.

### Transparency

- **Income and payroll taxes:** Taxes are more transparent than insurance premiums and other hidden fees.
- **System costs:** The Governor's plan assumes administrative costs will have close to commercial-level overheads (7%); and costs will grow at 4% annually. The assumptions and data points behind these projections and trends are unclear. It is unclear what specific savings have been accounted for.

### Participation

- **Health services provided:** The Governor's exclusion of dental, vision and hearing care does not take into account the health needs expressed by Vermont residents in consultations.
- **GMC Operations:** Neither a private contracting arrangement nor a public utility model enables meaningful public participation in governance.

## 2. METHODOLOGY

Over the past decade, many studies, analyses, designs, projections, and models have examined the feasibility of universal, publicly financed healthcare in Vermont. Produced by academics, consultants and government officials, this body of work offers a rich source of information for moving to the implementation stage of GMC. The HCHR campaign draws on this work to produce a concrete financing plan for implementing GMC in the timeframe set out by Act 48. Our contribution consists of creating data-based solutions that are grounded in the principle of equity and demonstrate that universal healthcare is economically viable and beneficial to the people of Vermont.

We consider the most recent report, the Governor's proposal, as the blueprint for GMC; indeed we believe the decision to implement public financing could have been made based on the evidence provided by that report, despite its shortcomings.<sup>7</sup> Since this did not happen, we chose to develop solutions to the problems raised in the Governor's report, and we put these forward here to facilitate the implementation of public healthcare financing. In other words, we seek to make the Governor's report more useful for moving GMC forward. This is why we have maintained comparability with the Governor's report wherever possible and why we explain our improvements next to his proposals. In addition to drawing on the Governor's report and appendices, we also received advice from his team, although two public records requests submitted by the campaign were not filled. Other key data sources for this report are the RAND report<sup>8</sup>, the UMass/Wakely report<sup>9</sup>, and the Hsiao report<sup>10</sup>.

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<sup>7</sup> Peter Shumlin et al., *Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Healthcare System*, December 30, 2014,

<http://hcr.vermont.gov/sites/hcr/files/2014/GMCRReport2014/GMC%20FINAL%20REPORT%20123014.pdf>.

<sup>8</sup> Christine Eibner et al., *The Economic Incidence of Healthcare Spending in Vermont*, January 2015, [http://www.rand.org/content/dam/rand/pubs/research\\_reports/RR900/RR901/RAND\\_RR901.pdf](http://www.rand.org/content/dam/rand/pubs/research_reports/RR900/RR901/RAND_RR901.pdf).

<sup>9</sup> University of Massachusetts Medical School Center for Health Law and Economics, and, and Wakely Consulting Group, Inc., *State of Vermont Health Care Financing Plan Beginning Calendar Year 2017 Analysis*, January 24, 2013.

<sup>10</sup> William C. Hsiao, Steven Kappel, and Jonathan Gruber, *Act 128 Health System Reform Design: Achieving Affordable Universal Health Care in Vermont*, February 17, 2011.

We used primary data sources for our revenue proposals, mainly from the IRS, the Bureau of Labor Statistics and the Vermont Department of Labor. We took the greatest departure from the Governor’s report with the development of a new payroll tax model, with the pro bono help of an expert data scientist.

## DATA LIMITATIONS

Unlike the Administration, we did not have access to the econometric microsimulation model used to develop the Governor’s projections and trend them forward. Instead, we developed our revenue proposals using the best available data, creating a new data model for a different type of payroll tax, and cross-checking our results against the Governor’s projections. While we had to limit our estimates to 2017, we are confident that our plan is viable in the longer term, since we project a very robust fiscal position for the GMC Fund in that year. We had no access to the primary data used by the Administration to prepare the Governor’s report; instead, we used the secondary sources listed above, supplemented with publicly available primary data. Throughout the report we explain the methodological limitations faced by the different parts of our plan.

We intend our proposals to revive a serious planning and transition process for public healthcare financing, and we expect that this will be supported by the Joint Fiscal Office (JFO). We recommend that the JFO and the Administration take our proposals and conduct their own cost and revenue analysis to ensure that the best and most updated data is applied to support the implementation of GMC.

## 3. POPULATIONS AND THE PRINCIPLE OF UNIVERSALITY

The principle of universality is an essential foundation of human rights. All people, without exception, are entitled to exercise their human rights, including the right to healthcare. This basic principle is undermined by the federal government’s failure to enact a national universal healthcare system, and leaves states challenged to establish subnational systems that, by definition, limit the population scope to state residents.

In Vermont, Act 48 adopted this definition of universality: “The purpose of Green Mountain Care is to provide, as a public good, comprehensive, affordable, high-quality, publicly financed health care coverage for all Vermont residents”<sup>11</sup>

However, the law also references federal limitations: populations currently part of federal health programs, specifically Medicare and TRICARE, cannot be automatically included in a state-based program. Federally supported or sponsored programs - Medicaid, CHIP, and federal employees health insurance - are more flexible and can be merged with GMC. Since Vermont already has a Medicaid waiver, those populations can be integrated as long as their benefits are not reduced. Federal employees are free to choose their health plans. As a result, our proposal assumes, as does the Governor’s, that Medicaid recipients and federal employees will be part of GMC, but that Medicare and TRICARE populations cannot be included without a federal waiver. We recommend that the state redouble its efforts to obtain a Medicare waiver, in particular since the Medicare program has significant gaps that leave many seniors without adequate access to care. This is why, in contrast to the Governor’s plan, we propose that GMC includes measures to increase seniors’ access to care, as outlined below.

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<sup>11</sup> 33 V.S.A § 1821, *An Act Relating to a Universal and Unified Health System*, 2011, <http://www.leg.state.vt.us/statutes/fullchapter.cfm?Title=33&Chapter=018>.

Wherever legally possible, our proposal follows Act 48’s requirement to include all residents, defined as every person living in Vermont, including immigrants with and without documentation.<sup>12</sup> Unlike the Governor’s proposal, we do not, at this point, seek to expand GMC to residents of other states who work in Vermont, although we propose including people from other states in the future.

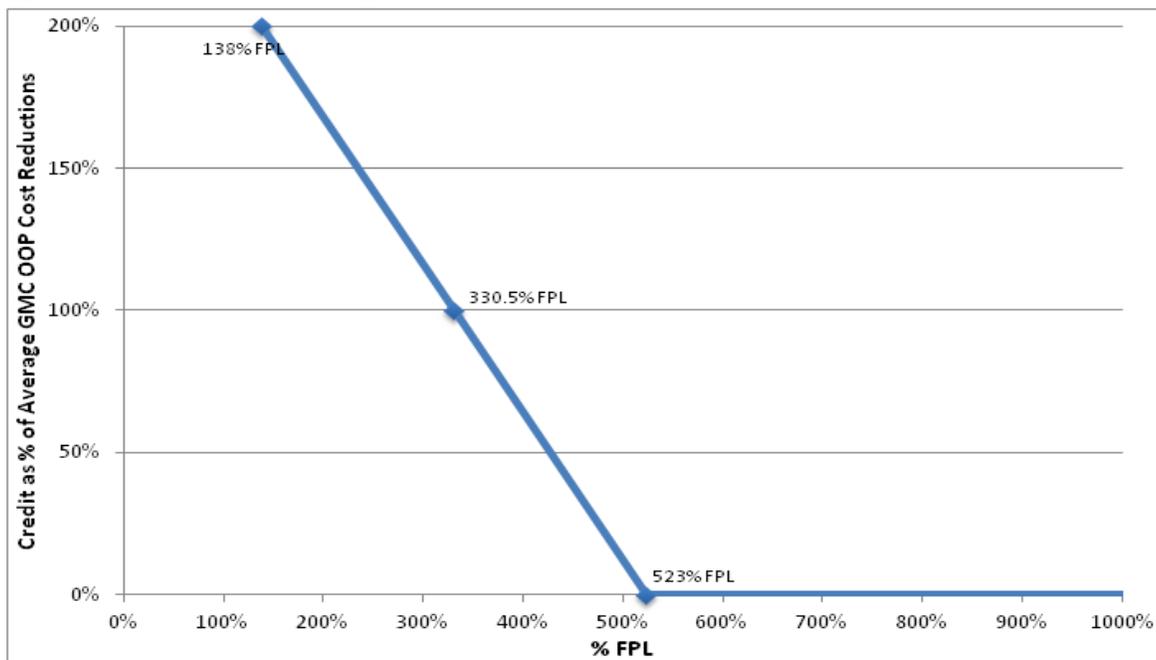
## MEDICARE AFFORDABILITY CREDIT

In order to remedy the disparity between access to care for individuals enrolled in Green Mountain Care and those enrolled in Medicare, which has much higher out-of-pocket costs, we propose a Medicare Affordability Credit for seniors with incomes under \$65,000.

Our Medicare Affordability Credit provides out-of-pocket cost relief for those seniors whose primary coverage is Medicare (i.e. not dual eligibles or others with secondary Medicare coverage, who are already eligible for GMC) and whose incomes are under 523% of the Federal Poverty Level. This is how the credit will work:

- GMC provides average savings of \$497 per person per year in out-of-pocket (OOP) costs in 2017 (based on the Governor’s projected \$258 million reduction in OOP Costs)
- Medicare recipients will receive an income-sensitive credit, guided by the general GMC OOP cost reductions, for out-of-pocket costs, provided their income is at or lower than 523% FPL. The credit amount will be determined based on based on a person’s income as a percent of FPL.
- The credit will start at 200% of the cost reduction received by those with Green Mountain Care primary coverage, and will decrease as incomes rise. Figure 1 below shows the credit amount in relation to income, as measured by % FPL.
- The Medicare Affordability Credit will be given to seniors in the form of a preloaded card that can be used at the point of service.

Figure 1. Medicare Affordability Credit



<sup>12</sup> Green Mountain Care Board, *Report Regarding the Costs and Health Services Provided to Undocumented Immigrants*, January 24, 2013, 7.

(See Appendix A for Methodology)

## OUT-OF-STATE RESIDENTS

The Governor's proposal included residents from other states who work in Vermont. We estimate that the cost of including this population, around 61,000 people, would be approximately \$350,000,000.<sup>13</sup> According to the Governor's modeling outputs, part of that cost would be offset by an income tax contribution from those out-of-state residents of \$150,000,000. We propose including out-of-state residents in a later phase of GMC and prioritize the core population – Vermont residents – as required by Act 48 in the initial establishment of GMC.

## 4. HEALTH SERVICES AND THE PRINCIPLE OF UNIVERSALITY

The principle of universality in healthcare has two aspects - who is included in the healthcare system and what services are included to ensure people's health. The right to healthcare extends to all people and includes the provision of all needed care. Act 48 requires that comprehensive, medically necessary services are provided to all residents, yet it leaves some specific decisions to the Green Mountain Care Board (GMCB). We assume that the GMCB will undertake a full review of the list of services proposed by the Governor, and we encourage the board to shift away from the insurance practice of listing benefits and instead presume the provision of all necessary care, as is the practice in other universal healthcare systems.

The HCHR Campaign proposes the inclusion of dental, vision and hearing care in GMC, all of which are excluded from the Governor's proposal. We also recommend a phased-in approach for long-term care, starting with a commission on long-term care. Such a commission should design public financing options for long-term care, with a view to phasing in long-term care over the first five years of GMC operations.

### DENTAL, VISION, AND HEARING CARE

Dental, vision and hearing care constitute medically necessary healthcare and as such must be part of Green Mountain Care, whose purpose is to provide comprehensive services that include all medically necessary care. The health and financial crisis caused by the widespread lack of access to dental care in particular has been well-documented.<sup>14</sup> The unjustifiable exclusion of certain body parts from the standard definition of benefits in the current health insurance system has harmed personal and population health alike. The Governor's proposal, however, did not include adult dental, vision and hearing care, although optional scenarios were prepared, based on the requirement in Act 48.

The HCHR Campaign proposes the inclusion of full adult dental, vision and hearing care. In calculating the cost of these services, we were limited to data provided in the Governor's report, as well as the Hsiao and UMass/Wakely reports. We chose the most comprehensive scenario calculated by the Administration<sup>15</sup> (Scenario 2, Appendix, Table B-1.2), and added federal employees (10,000) and employees in need of wrap-

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<sup>13</sup> This was calculated by multiplying the average cost PMPM by 12 months per year by the total number of commuters, 61,000.

<sup>14</sup> Green Mountain Care Board, *Vermont Dental Landscape Study*, JSI Research and Training Institute: Burlington, 2014, [http://gmcbboard.vermont.gov/sites/gmcbboard/files/Dental\\_Landscape\\_Report.pdf](http://gmcbboard.vermont.gov/sites/gmcbboard/files/Dental_Landscape_Report.pdf).

<sup>15</sup> Table B-1.2 in Shumlin et al., *Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Healthcare System*, Appendix B-1.

around for their employer-sponsored coverage (31,000)<sup>16</sup> We left all other assumptions in place, including the rather hefty 7% administrative costs built into the per member per month (PMPM) cost.

Table 1. Cost of Adult Dental Care

<b>GMC without Medicaid</b>	
PMPM cost	\$41.40
Estimated GMC Adults	300,150
Subtotal Cost	\$ 149,114,520
<b>Medicaid</b>	
PMPM cost	\$11.80
Estimated GMC Adults	81,822
Subtotal Cost	\$11,600,000
<b>Total 2017 Cost</b>	<b>\$160,714,520</b>

For vision and hearing care we used the only options provided by the Administration, and once again added federal employees and those with ESI.

Table 2. Cost of Adult Vision Care

<b>GMC without Medicaid</b>	
PMPM cost	\$7.80
Estimated GMC Adults	300,150
Subtotal Cost	\$28,094,040
<b>Medicaid (hardware only)</b>	
PMPM cost	\$4.73
Estimated GMC Adults	81,822
Subtotal Cost	\$4,600,000
<b>Total 2017 Cost</b>	<b>\$32,694,040</b>

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<sup>16</sup> This led us to overestimating the GMC population in need of these services, since we had insufficient data to subtract children, who already receive dental, vision and hearing care.

Table 3. Cost of Adult Hearing Care

<b>GMC without Medicaid</b>	
PMPM cost	\$0.52
Estimated GMC Enrollees	300,150
Subtotal Cost	<b>\$1,872,936</b>
<b>Medicaid (already covers hearing care)</b>	
PMPM cost	-
Estimated GMC Enrollees	-
Subtotal Cost	-
<b>Total 2017 Cost</b>	<b>\$1,872,936</b>

Providing adult dental, vision and hearing care at the level calculated by the Administration will add another \$195,281,496 to the total cost of GMC.

#### PHASING OUT USER FEES

The universal provision of care is also challenged by user fees, or cost-sharing, which create barriers to using needed services and result in inequitable access to care.<sup>17</sup> The Governor’s proposed actuarial value of 94%, while appropriately higher than commercial insurance plans, maintains out-of-pocket charges in GMC that disproportionately harm sick people and those with low incomes. The HCHR Campaign proposes a transition to a fully pre-paid, public healthcare system that decouples payment entirely from the use of care, so that healthcare becomes free at the point of service. Transitioning the proposed GMC population to 100% A/V would, according to the Governor’s report, cost \$201 million,<sup>18</sup> and we propose planning this transition as soon as possible.

## 5. HEALTH SYSTEM OPERATIONS AND THE PRINCIPLE OF ACCOUNTABILITY

Green Mountain Care is a public good and, as such, should be publicly financed and publicly administered. Any private subcontracting arrangement would not only significantly reduce transparency and accountability, but would also be more expensive, as experiences with the Catamount program have shown. The Governor’s proposal appears to take one step in the direction of ending the privatization of healthcare administration by proposing a public utility approach to administering GMC operations. His report suggested that the payment for health services be executed through a public-private partnership with the private partner operating as either a “designated public utility” or a “designated facilitator.” The private partner would be expected to bring

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<sup>17</sup> Healthcare is a Human Right Campaign, *Research Brief: Evidence for Adverse Health Effects of out-of-Pocket Costs (“cost-Sharing”)*, December 2014.

<sup>18</sup> Shumlin et al., *Green Mountain Care: A Comprehensive Model for Building Vermont’s Universal Healthcare System*, Appendix B–1.

appropriate financial reserves, expertise in administering coverage and negotiating rates, and access to other provider networks.

This public utility approach essentially warrants the publicly sanctioned and regulated private monopoly that comes with this designation, guaranteeing the regulated private company operating revenues and reasonable returns for investors.<sup>19</sup> In order to improve transparency, accountability, and participation, the HCHR Campaign instead proposes to move healthcare administration from the private to the fully public realm by establishing a public corporation as the administrator of GMC. This proposal is congruous with the mandate to provide publicly financed healthcare “as a public good” for all Vermont residents.<sup>20</sup> Rather than creating an entirely new body, we see the Green Mountain Care Board (GMCB) as best placed to take on this role. With additional powers, it could become a public corporation similar to other Vermont public authorities.

The facilitation of provider relationships and administration of claims through the GMCB is consistent with the powers already granted to the board by Act 48, and will ensure the public participation, transparency, and accountability that is required by GMC principles.<sup>21</sup> The GMC Board already is required to:

- Solicit public input (18 VSA §9378),
- Adhere to the state agency procedures relative to rules (18 VSA §9380), including those involving payment reform and cost containment (which are to be issued only after engaging Vermonters and submitting methodologies to the General Assembly (18 VSA §9375)
- Adopt an administrative appeals process (18 VSA §9381)
- Conduct investigations and issue subpoenas (18 VSA §9374(i))
- Establish consumer, patient, business and health care professional advisory groups to provide input and recommendations [18 VSA §9374(e)(1)]
- Seek advice from the Office of Health Care Advocate [18 VSA §9374(f)], and
- Make annual reports to the General Assembly (18 VSA §9375).

The conversion of GMCB to a public corporation could, far more efficiently than a public utility approach, fulfill Act 48’s directives to establish GMC in a “seamless and equitable manner” through a “simplified, uniform, single administrative system.”<sup>22</sup> Administrative functions unified in a single public corporation and coordinated with the Agency would include a range of tasks, as listed in the Governor’s report. Fifteen function areas are flagged for “further analysis,” among them medical necessity determinations, enrollment, program integrity and customer service. Each of these function areas is, in our opinion, clearly a public responsibility, to be carried out by a public corporation or a public agency.<sup>23</sup>

We propose that the GMCB become the successor public corporation to Blue Cross Blue Shield Vermont (BCBSVT), which is a non-profit public asset of Vermont that currently possesses \$214 million in assets, with \$81

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<sup>19</sup> 30 VSA §1 et. seq., *An Act Relating to a Universal and Unified Health System*, 2011.

<sup>20</sup> 33 V.S.A § 1821, *An Act Relating to a Universal and Unified Health System*.

<sup>21</sup> 18 VSA §9371.

<sup>22</sup> See 33 VSA §1821 and 18 VSA §9373(5).

<sup>23</sup> For example, Act 48’s goal is to “ensure universal access to and coverage for high quality, *medically necessary* health services for all Vermonters.” 18 VSA §9371(1). Historically, privatized determinations of medical necessity have frequently led to unnecessary denials and costly grievance and appeals. Additionally, there is little justification for bifurcating customer service and grievances, with a private entity handling the former and a public agency the latter (as the Governor suggests). Efficiency demands unitary administration of both these functions, as well as fraud and abuse determinations. As the Agency of Human Services already is responsible for GMC eligibility determinations under 33 VSA §1824, efficiency also warrants the Agency handle GMC enrollment as well.

million in liabilities.<sup>24</sup> The roughly \$132 million in surplus it currently maintains could be used to fund the transition to and administration of GMC, were the non-profit company dissolved and the GMCB transformed into a public corporation.

Last year, the General Assembly appeared to anticipate such a conversion by directing the Vermont Department of Financial Regulation to examine the financial and legal considerations of Health Insurance Company dissolution.<sup>25</sup> The Department opined that BCBSVT could be dissolved by statute, yet withheld conclusions about asset transference absent a specific proposal.<sup>26</sup> It did note, however, that non-profit dissolution customarily warrants the transfer of assets to a charity or public corporation.<sup>27</sup> We propose to give the GMC Board the powers to be this corporation.

This approach will reduce GMC operations cost, starting with the insurance reserves included in the Governor's plan. The Governor determined that the state would need to have access to reserves to account for "claims risk" and unexpected slowdowns in the economy. The Administration's actuarial firm, Wakely Consulting Group, estimated that GMC would require between \$70 and \$117 million in reserve capital were it treated identical to an insured product.<sup>28</sup> In short, were GMC analyzed under a traditional claims risk analysis, BCBSVT converted assets of \$132 million would easily meet GMC reserve requirements, with \$15 million to spare.

The Governor, however, also pointed out that GMC reserves would have to provide a hedge against slowdowns in state tax collection. Wakely put this total reserve estimate at \$136 million.<sup>29</sup> The Governor then took the Wakely estimate and increased the reserve requirement to \$146.2 million, explaining that this would constitute five percent of the amount of state taxes in the GMC fund, comporting with state law requirements. This reserve would not only cover GMC, but would provide an additional and new reserve for Medicaid.

In conclusion, the Governor recommended a one-time bond issue to establish reserves at a hefty \$200 million, which is \$54 million over his own reserve estimate and \$68 million beyond the Wakely estimate. A comparison of these reserve estimates is set forth in Table 4, with a comparison to BCBSVT's assets that would be available through conversion.

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<sup>24</sup> BCBSVT's 2013 Annual Statement, on File with the VT Department of Financial Regulation.

<sup>25</sup> VT Dept of Financial Regulation, *When A Health Insurer Ceases Business in Vermont, Legal and Financial Considerations* (July 15, 2014), at p. 51.

<sup>26</sup> BCBSVT is a creation of state law, See 8 VSA §4511 et. seq.; 8 VSA §4581 et. seq.; and 11B VSA §1 et. seq. In 1984, the Vermont Supreme Court found that BCBSVT "is not a private business operating freely within the competitive marketplace; it is a quasi-public business subject to the regulation of the commissioner." *In re Vt. Health Serv. Corp.*, 144 Vt.617, 482 A.2d 294 (1984). See also n.6, at p. 24. It has no investors, but simply a governing Board of Directors

<sup>27</sup> BCBSVT itself sought a conversion to profit status in 2002, but the legislature refused.

<sup>28</sup> Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Health Care System, Submitted by Governor Peter Shumlin to the Vermont State Legislature, December 30, 2014, (hereinafter "Governor's Plan") p26.

<sup>29</sup> Wakely Letter to Michael Costa, Dec. 24, 2014. Governor's Report, Appendix D.

Table 4. Reserves Needed for GMC

Reserve Assumption	Estimated Reserve Needed	Reserve Provided by BCBSVT Conversion	Difference between Reserve Needed and BCBSVT Net Assets
GMC treated as private product w/traditional claims risk	\$70 to \$117 million	\$132 million	+ \$15 million
GMC w/traditional claims risk plus tax revenue downturn risk [Wakely Estimate]	\$136 million	\$132million	(-\$4million)
GMC w/traditional claims risk plus tax revenue downturn risk [Governor Estimate]	\$146.2 million	\$132 million	(-\$14.2 million)
Governor's Final Recommendation	\$200 million	\$132 million	(-\$68 million)

As Table 4 shows, BCBSVT assets would cover GMC reserves using a traditional claims risk analysis. They would fall \$4 million short of providing an expanded reserve of \$136 million calculated by the Wakely Group as a hedge against the added risk of tax revenue shortfalls. Using the Governor's augmented hedge against such tax revenue lags, BCBSVT assets fall \$14.2 million short. The Governor's desire for a hefty reserve of \$200 million exceeds actuarial estimates, and is therefore not the option we chose.

Given the above, it is clear that the conversion of BCBSVT would obviate the need for the \$200 million one-time bond proposed by the Governor to establish a large reserve.<sup>30</sup> Instead, solid GMC reserves can be obtained through the \$132 million obtained through BCBSVT conversion, plus a one-time infusion of \$14.2 million of state revenue.

As a successor public corporation, the GMC Board also could absorb the BCBSVT staff, utilizing its experience in claims administration and provider negotiation, while reducing administrative costs.<sup>31</sup> While it is likely that economies of scale and savings garnered from reduced functions (such as auditing, actuarial and other consulting services, etc.) are likely to reduce administrative costs below the Governor's estimate, we conservatively restrict our projected cost savings to the item of debt service costs for an insurance reserves bond, and leave the Governor's 7% administrative cost assumption in place.<sup>32</sup>

<sup>30</sup> And its \$44 million in debt service costs, annualized over the first five years of GMC. Governor's Proposal, p. 27.

<sup>31</sup> According to its 2013 Annual Statement, BCBSVT's President and Chief Executive Officer is paid \$553,059 in annual salary, with \$16,406 in other compensation. In fact, the lowest salary of its ten company officers is \$214,250, with the officer salary average at \$296,159. The actual total is \$3,661,911. [All figures taken from BCBSVT 2013 Annual Statement filed with the Vermont Department of Financial Regulation, Act 150 (2011 Adj. Sess.) and FY 2013 Addendum to Health Insurer Annual Statement.] In contrast, the head of the State's Finance and Management Department is paid \$92,141 annually and the eleven staff persons that make up the Department are paid an average of \$76,219. In fact, the \$3.6 million currently paid BCBSVT officers is equivalent to the total FY 2015 state appropriation for the personnel costs of the Vermont legislature.

<sup>32</sup> The Hsiao report found that BCBSVT could save between \$43.4million and \$56 million in administrative costs annually were Vermont to convert to a single payer or single pipe system, reducing BCBSVT administrative costs to as low as 4.7% to 6.7% of premiums. Act 128, Health System Reform Design, Achieving Affordable Universal Health Care in Vermont, (Feb., 2011), p.41.

The annualized cost of GMC is adjusted in Table 5 to reflect the net result of BCBSVT conversion, and the reduced need for public contribution to the GMC reserve.

Table 5. 2017 Annualized Green Mountain Care Cost

GMC Plan (Costs Excludes Out-of-pocket Costs)	Value in Million of Dollars
<b>Coverage</b>	
GMC Primary (Non Medicaid Eligible)	2,171
GMC Medicaid Primary	1,126
State Medicaid Fixed Costs	680
Medicaid Dual Eligible	259
Employer Sponsored Insurance Wrap	28
<b>Total Cost of Coverage</b>	<b>4,263</b>
<b>State Operations Cost</b>	
Insurance reserves*	146.2
Insurance reserves from BCBS	(132)
Contingency	10
<b>Total GMC Annual Cost</b>	<b>4310.2</b>

\* A one-time infusion of \$14.2 million in state revenue is needed to bring reserve to \$146.2 million

The conversion of BCBSVT to a successor public corporation, such as the GMC Board, could reduce annualized GMC costs by \$44 million, eliminating the bond for insurance reserves proposed by the Governor. Including the one-time revenue infusion of \$14.2 million to establish a \$146.2 million reserve, total GMC costs would be reduced by \$186 million between 2017 and 2021 compared to the Governor’s projections.<sup>33</sup>

## 6. HEALTH SYSTEM COSTS AND THE PRINCIPLE OF TRANSPARENCY

One of the great opportunities of Green Mountain Care is to create a transparent, accountable public healthcare system in Vermont. The shift from private, market-based healthcare financing to public, tax-based financing would bring the system under public oversight, yet clear transparency and accountability mechanisms are required to facilitate the meaningful exercise of such oversight.

At this point, important policy choices, in particular relating to the overall cost of GMC, suffer from a lack of transparency. It is impossible for anyone outside the Administration to accurately project the cost savings that would come with a shift to Green Mountain Care. The UMASS/Wakely study and the Hsiao study both estimate that GMC would save hundreds of millions of dollars per year,<sup>34</sup> yet the underlying data used to make these

<sup>33</sup> Shumlin et al., *Green Mountain Care: A Comprehensive Model for Building Vermont’s Universal Healthcare System*, 33.

<sup>34</sup> The UMASS/Wakely report estimates that administrative savings alone will save Vermont between \$116.2 million and \$535.2 million by 2020 (UMASS/Wakely 50). The Governor’s report estimates that GMC would save \$378 million over its first five years (Shumlin 55), and includes these savings in the 4% GMC growth rate. The Hsiao report estimated that in a single-payer system, Vermont would see savings of \$530 million in year one of GMC (with year one beginning in 2015, and measured in 2010 dollars), and \$1.55 billion in absolute savings by year 10 (Hsiao 38). It also estimated that in a multi-payer “single pipe” system, Vermont would see savings of \$320 million in year one and \$980 million in absolute savings by

calculations are not readily available to the public. The Governor's proposal does not appear to fully account for system-wide cost savings.<sup>35</sup> His report projects a cost of \$4.527 billion for GMC in 2017 (including out-of-pocket costs) and estimates that costs will rise each year at 4%.<sup>36</sup> This rate is assumed to be lower than the current system's growth trend, yet savings figures are not disaggregated.

Without access to detailed data underlying the various cost and trend projections, the HCHR Campaign has to accept the Governor's cost projections. However, we seek to highlight key areas in which research demonstrates significantly lower costs under universal, publicly financed healthcare than under a fragmented, market-based system. Some of these areas have already been explored in previous studies —although not explicitly calculated as part of GMC cost savings— while others have largely been ignored, and merit further exploration.

**Administrative savings:** Vermont could realize significant administrative savings as soon as GMC goes into effect, and could also bend the healthcare cost curve over time, reigning in the growing cost of care. These administrative savings would come from both the payer side and the provider side, and could include:

- **Moving from private to public insurance:** By moving from a fragmented market-based health insurance system to a single public payer for most people in Vermont, GMC would eliminate or reduce costs that private insurance companies currently pay for business development, marketing, sales, underwriting, and risk analysis. The Governor's report pegs GMC's administrative overheads at 7%, which appears to be a rather conservative figure.
- **Create a public corporation to manage payments:** Even with multiple payers, Vermont could greatly simplify payment administration by creating a single public corporation to handle all medical payments within the state.<sup>37</sup> This public entity would reduce redundant administrative functions among payers (like selecting, negotiating, and contracting with providers)<sup>38</sup> and would greatly simplify billing for providers.<sup>39</sup>

**Price controls and price uniformity:** In the current system, prices for health services are neither sufficiently scrutinized or controlled, nor uniform across the system. High prices especially by large, near monopoly providers contribute to significant system-wide cost increases. Since the GMCB started approving hospital budgets, costs have decreased, but a full price control function has not yet been implemented.<sup>40</sup> In addition to price controls, unifying the cost of services - patients with the same medical procedures pay very different rates - would simplify billing for both payers and billers, resulting in further cost savings. An all-payer rate setting system is assumed by the Governor's report, but actual costs savings are not specified beyond the assumption of a 4% growth rate. As the terms of an all-payer system will be developed by the GMCB, and are dependent on a federal waiver, savings are difficult to project. Given Maryland's mixed experience with an all-payer system,<sup>41</sup> it

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year 10. Because GMC would reduce the number of payers in Vermont but would still include more than one payer, an updated estimate for GMC should fall between these two figures.

<sup>35</sup> Gerald Friedman, *Governor Shumlin's Report on Green Mountain Care*, January 6, 2015.

<sup>36</sup> Shumlin et al., *Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Healthcare System*, 31.

<sup>37</sup> Providers who treat out-of-state residents would still have to bill payers in other states separately.

<sup>38</sup> Hsiao estimates that between 1% and 3% of Vermont's total healthcare expenditures could be eliminated by simplifying payer administration through a single-pipe or single-payer system (41).

<sup>39</sup> Hsiao estimates that between 2.65% and 3.53% of Vermont's total healthcare expenditures could be eliminated by simplifying billing for providers through a single-pipe or single-payer system (44, 46).

<sup>40</sup> Al Gobeille, Presentation on the Green Mountain Care Board, House Health Committee, January 13, 2015; <http://legislature.vermont.gov/assets/Documents/2016/WorkGroups/House%20Health%20Care/Green%20Mountain%20Care%20Board/W~Al%20Gobeille~Presentation%20on%20the%20Green%20Mountain%20Care%20Board~1-13-2015.pdf>

<sup>41</sup> Lena H. Sun and Sarah Kliff, "Maryland Already Sets Hospital Prices, Now It Wants to Cap Their Spending," *Washington Post*, May 25, 2013.

seems necessary for rate setting to go hand-in-hand with other payment reform measures, such as global budgeting and moving away from fee-for-service payments. The Governor's report assumes a shift from volume-based to outcomes-based provider payment, but savings are not specified.

**Providing appropriate care:** Vermont's market-based healthcare system skews incentives for healthcare providers, creating financial incentives to overprescribe tests and treatments in some cases, and to skirt the provision of preventive and primary care in others. Key policy changes could help ensure that medical decisions are based on people's health needs, not finances, resulting in better cost effectiveness.

- **Reducing "utilization" through provider-level measures:** The Governor's report adds cost from increased utilization due to improved access to care, yet it does not seem to account for provider-level reforms that could lead to more cost-effective practices. The fee-for-service payment model is known to lead to the overprescription of diagnostic tests and other procedures, and a lack of coordinated patient care across different providers leads to duplication.
- **No-fault care for injuries from medical care:** As the Hsiao and UMASS/Wakely studies explain, the risk of being sued for malpractice is a major concern for medical providers, so much so that at least 2% of healthcare in the U.S. is estimated to be "defensive medicine," unnecessary healthcare that providers prescribe not for medical reasons, but to avoid lawsuits.<sup>42</sup> By shifting from a malpractice system to a no-fault administrative system, Vermont could cut its medical costs by 2%.

**Improved public health and productivity:** Underinsurance and uninsurance in the current system mean that people delay or forego needed care, or are forced to cut back on their work hours or downscale their spending on rent and other goods and services. By guaranteeing access to care, Green Mountain Care would likely improve the health and productivity of Vermont's population. Better population health and worker productivity can be linked to economic growth as well as lower healthcare costs.<sup>43</sup> These benefits to the state can be very significant and should be explored thoroughly.

**Integration of workers' compensation with GMC:** Vermont's workers' comp system is designed to get workers who are injured or made ill on the job healthcare and, if needed, replacement wages for time that they are unable to work. It is financed separately from the rest of the healthcare system (through employers' workers' compensation insurance premiums), which requires its own set of public and private administration. Integrating or aligning the healthcare side of workers' comp would streamline healthcare access for workers and would also reduce redundant administration, saving money. A portion of what employers are currently paying in workers' comp insurance premiums could simply be shifted over into taxes paid into Green Mountain Care.

**Rein in pharmaceutical costs:** Vermont has several options to help reign in high drug prices. Act 48 (Section 18) sets out that a single prescription drug formulary be used by all payers along with a uniform set of drug management rules, and that this be combined with a single mechanism for negotiating rebates and discounts across payers. Examples of significantly more cost-effective provision of pharmaceuticals abound in comparable countries. Canada, for example, uses formulary management, reference-based pricing, price freezes, and limits on markups to keep a lid on the cost. Economists have stipulated that mark-ups for drug prices in the non-negotiated U.S. market reach 37.5%,<sup>44</sup> and suggest that states move to act as bulk buyers and negotiate drug prices with pharmaceutical companies.<sup>45</sup>

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<sup>42</sup> Hsiao estimates that Vermont could save 2% of its healthcare costs by moving to a no-fault system for compensating injuries or illnesses resulting from medical care (p. 37).

<sup>43</sup> Anne Alexander, *Treating Health Care As a Human Right in Montana: A Cost-Benefit Analysis* (National Economic and Social Rights Initiative, June 2010).

<sup>44</sup> McKinsey Global Institute, "Accounting for the cost of healthcare in the United States," January 2007.

<sup>45</sup> Gerald Friedman, *Single Payer Rhode Island: Impact and Implementation*, December 2014.