To: Vermont Partners for Health Care Reform

From: Avalere Health

Date: November 14, 2013

Re: Evaluation of Vermont Health Care Reform Financing Plan

EXECUTIVE SUMMARY

The State of Vermont commissioned a study to estimate the cost of the single-payer plan contemplated by Act 48 – named Green Mountain Care (GMC) – and then to lay out options for financing that cost. The analysis (hereinafter, the "Financing Plan") concluded that the State would need to raise $1.61 billion from Vermont taxpayers in 2017 to fund the plan. The amount to be raised is comparable to Vermont's tax collections from all sources today. Some of the new tax burden would be offset by the elimination of direct costs for private health coverage, since the State expects to become the health insurer for most Vermonters.

The Financing Plan did not designate specific revenue sources for the single-payer plan. The Governor is due to issue a report in 2014, and the General Assembly will consider the Administration's recommendations for revenue sources to fund the program in early 2015.

Avalere Health was retained by Vermont Partners for Health Care Reform, a group comprised of Vermont health care providers, a health plan provider and employers, to make an independent assessment of the Financing Plan's cost estimate and its key assumptions. To inform the appraisal, Avalere conducted an extensive review of Vermont's health reform documentation and interviewed key Vermont stakeholders. Avalere's evaluation assessed the validity of the assumptions of the Financing Plan, identified outstanding questions not directly addressed in the Financing Plan, and outlined potential impacts the Financing Plan may have on providers, payers, employers, and consumers in Vermont.

To furnish generous coverage to Vermonters for the least cost, the Financing Plan's cost of $1.61 billion is based on key assumptions in order to seek savings by offsetting expected growth in coverage and consumption of health services. The authors of the Financing Plan made pivotal assumptions on such factors as:

- How many people will receive coverage
- How frequently people will utilize various health care services
- How much each of these services will cost
- How much savings can be found from administrative simplification

As acknowledged by the analysts who prepared the Financing Plan, each of these assumptions has a wide potential range of outcomes, and small changes in the assumptions can lead to large differences in total costs, especially when compounded across several years. Changes in key assumptions such as provider payment rates and administrative savings could fundamentally increase the cost of the single-payer plan that the General Assembly will be considering in 2015.

While Avalere did not produce a different model, we evaluated alternatives provided in the Financing Plan regarding alternatives for provider payment rates and administrative savings. Avalere believes that a more appropriate expected cost, assuming the same program scale expected by the Financing Plan, could be $1.9 to $2.2 billion, or about 20 to 35 percent higher than the current estimate.

Table 1: Potentially Higher Costs for GMC from Varying Key Assumptions

$ in millions	Financing Plan (Mid-Range)	Alternative Assumptions	
Provider payment rates	105% Medicare	115% Medicare	125% Medicare
- Net change in payments	($155)	$73	$301
Implied provider payment reduction	*-16%*	*-11%*	*-6%*
Administrative cost savings			
- Payers	($126)	($50)	$0
Amount to be financed	**$1,611**	**$1,915**	**$2,193**

Source: Financing Plan and Avalere analysis

Assessment of Key Financing Plan Assumptions

- **GMC's plan to pay providers at 105 percent of Medicare may jeopardize access to health care services.** The Financing Plan specifically assumes that GMC will pay providers at 105 percent of Medicare rates beginning in 2017. Since GMC does not replace Medicare, the average payment for providers would be 103 percent of Medicare. We estimate that providers in Vermont today receive 122 percent of Medicare, on average, so it appears that

the Financing Plan is asking providers to absorb a cut in payment of 16 percent or nearly one dollar in six. This measure could create a disincentive for health care practitioners to work in Vermont if payments to providers in other states prove to be higher in comparison.

Moreover, Medicare payment may be an unreliable benchmark. Medicare rates do not accurately reflect different providers' costs. For example, the Medicare Payment Advisory Commission (MedPAC) estimates that the average acute-care hospital has a Medicare margin of -5.8 percent – that is, a loss. The Green Mountain Care Board (GMCB) acknowledges that hospital costs are often above Medicare payments, noting that estimates range from 79 to 100 percent of costs; the GMCB also notes that some categories of expenditures are not covered by Medicare. For physicians, Medicare's payment formula is subject to annual machinations by Congress; if Congress should fail to reconcile payment in any year, physicians whose payments are tied to Medicare policy may see a dramatic drop.

- **The Financing Plan assumes that utilization will continue to increase and provider payment will need to be reduced to help offset higher health care costs.** The Financing Plan assumes that the GMC plan offered to Vermont residents will have an actuarial value level of 87 percent and the Financing Plan forecasts spending from 2011 to 2017 using data from sources such as the Medicare Trustees Report, National Health Expenditure Projections, and state Medicaid data. Much of this data is developed by actuaries who are not looking just at Vermont, and do not include projections of the potential effects of state-based reforms. Health care utilization in Vermont slowed down significantly during the 2010-2011 period. On a per capita basis, the annual growth rate for total health care costs in Vermont dropped significantly from 7-8 percent per year in 2008 and 2009 to 4.2 percent in 2010 and 0.9 percent in 2011. The GMCB estimates per capita spending will return to much higher levels in 2012-2014, and the Financing Plan uses similar assumptions to forecast per capita spending rates through 2017.

- **The plan assumes large administrative savings that may not be feasible to achieve.** Act 48 presumes that private insurers in Vermont will be replaced by a state agency that would run Green Mountain Care. The Financing Plan assumes that this agency's administrative costs will amount to roughly 7 percent of total health spending rather than the 12 percent that is the national average for private insurers today.

  More recent estimates from the GMCB suggest that the average administrative ratio for private plans in Vermont for 2013 is actually 6.7 percent. Since private insurance companies in Vermont – in particular, the state's dominant private insurer, Blue Cross Blue Shield of Vermont – have already reduced the administrative margin to levels below the mid-point target in the Financing Plan, it may not be feasible for the state-run program to achieve additional savings.

In addition, Vermont's health care providers may not realize the projected administrative cost savings due to their continued interactions with Medicare beneficiaries, with people covered by employer plans exempted from state regulation under ERISA, and with patients from out of state, all of whom will be outside of Vermont's single-payer program.

- **The Financing Plan assumes most employers will stop offering coverage to employees.** The Financing Plan assumes that nearly 70 percent of Vermont residents will have primary coverage through Green Mountain Care by 2017. This includes all Medicaid beneficiaries plus most people who purchase insurance individually. It also includes 84 percent of people who currently have employer-sponsored coverage. Whereas one of the Affordable Care Act's goals is to increase employer-sponsored coverage via a penalty for non-coverage, the incentives for employers in GMC are unknown since Act 48 does not specify any rules and the source of financing is as yet undetermined. As such, it is difficult to say if the estimates for the number of people to be covered by GMC are accurate, which in turn makes it difficult to accept some of the assumptions regarding savings.

Outstanding Questions

- The Financing Plan is one of several pieces of a plan that has been developed to help Vermont build a framework for establishing Green Mountain Care. It must be read in conjunction with other documents including the Blueprint for Health materials, the State Innovations Model grant proposal and operating plan, the Healthcare Workforce Strategic Plan, GMC Board meeting minutes and other relevant health care reform foundation. There remains considerable uncertainty regarding the effects that reforms included in these other documents will have on spending growth. If these reforms have the effect of reducing utilization patterns, total spending in Vermont may be lower than the levels estimated by the Financing Plan.

- The Financing Plan aims to replace the current fee-for-service payment system with a system of global payments by 2017. The Financing Plan report does not describe details of the new provider payment system. Instead, the plan assumes a reimbursement rate of 105 percent of Medicare. Other documents issued by or on behalf of State agencies do touch on new payment models but they lack specificity sufficient to evaluate their potential impact.

- Payment rates for out-of-state care will be contingent on making arrangements with out- of-state providers, which are yet to be determined. Additionally, out-of-state care is likely to affect the administrative savings projections, as providers will likely still have to deal with out-of-state payers and continue administrative functions for out-of-state patients.

Evaluation of Stakeholder Impact

- **Private insurers.** If GMC becomes the primary insurer for most Vermonters who are not already covered by public programs – Medicare and Medicaid, mainly – there will be no role, or at minimum a radical change to the business model, for Vermont's private insurers. Of note, the nonprofit Blue Cross Blue Shield of Vermont would have little reason to exist.

- **Health care practitioners.** As proposed, the Financing Plan could create a significant disincentive for health care practitioners to work in Vermont due to reduced compensation and increased payment uncertainty compared to what they might earn in other states.

- **Hospitals.** The Financing Plan assumes there will be an instantaneous cut in provider payment rates at the start of 2017 and it does not consider the differences among hospitals and other health care facilities relative to the benchmark Medicare payment rate. Some facilities could suffer gravely if actual policy conforms to the assumption.

- **Employers.** GMC will have differential impacts on employers. Some may see their workers gain coverage at a cost that is lower than what they pay today. Depending on the form of assessments used to finance GMC, other employers could continue to pay to insure their workers while also contributing to pay for the health costs of other businesses' employees.

- **Consumers.** GMC will likely increase the demand for health care services in Vermont and residents may also be subject to broad-based taxes to help fund GMC. Some consumers will see a net improvement in their direct and indirect costs of health care while others will pay more.

Conclusion

The authors of the Financing Plan took care to note that they made many assumptions and that there is variability around each of their point estimates. Avalere agrees that these factors make the projected funding need of $1.61 billion uncertain. Applying what we consider to be more reasonable assumptions for provider payment rates and administrative savings, we conclude that funding needs could be $1.9 to $2.2 billion.

Only when the Governor issues his proposal for ways to raise the necessary funding will it be possible to assess the effects on the costs – taxes and others – and benefits to different groups of Vermont residents and businesses in general. We can say that the effects on the health care sector appear to be adverse: for providers it appears that average payments will be significantly lower and for health insurers there appears to be no basis to continue to operate in the state.

I. Background of Evaluation Report

The State of Vermont released its Health Care Reform Financing Plan (hereinafter referred to as the "Financing Plan") in January 2013.[1] A group of Vermont organizations – Fletcher Allen Health Care, Blue Cross Blue Shield of Vermont, the Vermont Business Roundtable, the Vermont Chamber of Commerce, the Vermont Medical Society, the Vermont Association of Hospitals and Health Systems, and the Vermont Assembly of Home Health and Hospice Agencies – collectively referred to as "Vermont Partners for Health Care Reform," retained Avalere Health ("Avalere") to objectively evaluate the Financing Plan's potential effects on health care administration, financing, and delivery in Vermont.

Our focus was the portion of the plan due to be implemented in 2017 in which a large portion of Vermont's population would become insured for health care by one public payer that would be called Green Mountain Care (GMC). Our evaluation concentrated on discerning whether the Financing Plan was valid and if the proposed financing amount, $1.6 billion, is adequate for the financing of a single payer system in Vermont in 2017.

As part of the evaluation, Avalere conducted an extensive document review to understand the background of the proposed reform and the unique aspects of Vermont's health care system. Additionally, Avalere interviewed several stakeholder groups in Vermont, identified by the Vermont Partners, to gain deeper insight about their concerns and perceived impacts of GMC. Among those interviewed were State agency officials and leaders of the Green Mountain Care Board, an existing body that today regulates many aspects of health care delivery and financing in Vermont. We also spoke with representatives of the consulting organizations that produced the Financing Plan under contract to the State.

Avalere completed an analysis of the Financing Plan by examining the assumptions used to develop the plan, identifying outstanding questions not addressed in the plan, and describing the plan's potential impact on Vermont's health care providers, health plans, employers and consumers.

II. Assessment of Financing Plan's Assumptions

The Financing Plan projects the total spending for all Vermont residents in 2017 will reach $5.4 billion without GMC and $5.5 billion with GMC. It calls for new public funding of $1.61 billion beginning in 2017 to pay for the program, essentially to replace current spending by employers and individuals on private health insurance premiums and a portion of consumers' out-of-pocket

[1] http://www.leg.state.vt.us/reports/2013ExternalReports/286250.pdf

costs. Whether businesses or individuals would be taxed to pay for Green Mountain Care is not specified; a number of financing options are listed in the report for policymakers' consideration.

The authors of the Financing Plan made pivotal assumptions on such factors as:

- How many people will receive coverage
- How frequently people will utilize various health care services
- How much each of these services will cost
- How much savings can be found from administrative simplification

As acknowledged by the analysts who prepared the Financing Plan, each of these assumptions has a wide potential range of outcomes, and small changes in the assumptions can lead to large differences in total costs, especially when compounded across several years. In addition, the same total spending estimate can be achieved by reducing the growth rate on one of the assumptions and increasing the growth rates on the other assumptions.

Both the analysts who modeled the plan and the State officials who commissioned the analysis told us that all figures used in the Financing Plan are planning assumptions, not definitive policy. Although not reflected in the Financing Plan, the State officials said that policy decisions will be made over the span of time before GMC goes live and that most particulars will be negotiated with the affected stakeholders.

A. The Financing Plan assumes most employers will stop offering coverage to employees without assessing the potential incentives

The Financing Plan assumes that nearly 70 percent of Vermont residents will have primary coverage through Green Mountain Care by 2017. This includes all Medicaid beneficiaries plus most people who purchase insurance individually. It also includes 84 percent of people who currently have employer-sponsored coverage. GMC is proposed to start in 2017, three years after the expansion of health insurance due to the federal Affordable Care Act (ACA).

Whereas one of the ACA's goals is to increase employer-sponsored coverage via a penalty for non-coverage, the incentives for employers in GMC are unknown since Act 48 does not specify any rules and the source of financing is as yet undetermined. As such, it is difficult to say if the estimates for the number of people to be covered by GMC are accurate, which in turn makes it difficult to accept some of the assumptions regarding savings tied to administrative simplification.

Table 1: Assumed Coverage Shift from Launch of GMC

Employer Category	Percent of Enrollment Shifting to GMC
Small group members	70-100%
Large group members	
Health system employees	80-100%
State government	100%
National group members	50-90%
Local employers	70-100%

Source: Financing Plan

In conversations with employers in Vermont, we observed a sense of uncertainty about the launch of the GMC plan. Most expressed discontent with the growth of commercial insurance costs, noting that they cannot afford to keep paying ever-rising premiums. Yet they could not say if they will drop health benefits for workers in favor of the GMC plan in 2017 because they did not know how the State would finance the costs. If the program is financed via a new payroll tax, most small, locally-based employers would likely drop existing coverage in favor of the GMC plan. If the new program is financed by other means, some employers may decide to keep their current coverage.

Larger employers based out of state, especially those that self-insure, are more reluctant to move employees to a state-run program, as it would create inconsistencies across their populations and could have adverse financial consequences for their self-insurance risk pools. State officials acknowledge that Vermont has no power to regulate the actions of self-insured employers, whose health benefits programs are governed by the federal Employee Retirement Income Security Act (ERISA).

The Financing Plan does not attempt to factor these different choices into the assumptions regarding employer behavior, and instead uses a possible range of dropping assumptions specific to the large group market. Of note, the Financing Plan finds that there would be higher overall costs for the GMC plan if fewer employers drop coverage. Fewer employers dropping coverage would also limit the estimated administrative cost savings that providers may experience under GMC. (See below for a complete analysis of the administrative savings.)

B. The Financing Plan uses Medicare payment rates as a benchmark for future provider payment under GMC, despite evidence that Medicare often pays below cost

Medicare payment rates do not accurately reflect providers' costs. In conversations with State officials, one of the explanations they gave for using Medicare as the base for GMC rates was that Medicare payments represent the cost of care. However, Medicare rates vary

substantially by provider type, and also reflect the efforts of federal policymakers to adjust payments for other reasons.

For example, the Medicare Payment Advisory Commission (MedPAC) estimates that the average acute care hospital has a Medicare margin of -5.8 percent – that is, a loss.[2] The Green Mountain Care Board[3] (GMCB) acknowledges that hospital costs are often above Medicare payments, noting that estimates range from 79 to 100 percent of costs; the GMCB also notes that some categories of expenditures are not covered by Medicare.[4]

Conversely, MedPAC estimates that Medicare payment rates for other services, notably skilled nursing facilities, range above the average cost. MedPAC also notes that the average Medicaid reimbursement to skilled nursing facilities (SNFs) is well below cost, so these facilities subsidize Medicaid patients with Medicare revenues. Given the large variation in Medicare payment rates, it would be a challenge to apply the same Medicare-based payment methodology for GMC that includes both commercial and Medicaid markets.

Table 2: Estimated National Medicare Margins for Health Care Providers

	Medicare Margin		
Provider Type	2009	2010	2011
Acute Care Hospitals	-5.4%	-4.7%	-5.8%
Skilled Nursing Facilities	18.0%	18.5%	22%-24%

Source: MedPAC "Report to the Congress: Medicare Payment Policy". March 2013.

The Financing Plan assumes a payment rate that would significantly cut overall payment for most providers. The Financing Plan includes the current estimated payment rates compared to Medicare for commercial plans (155 percent) and Medicaid (82 percent). While the Financing Plan also includes the overall distribution of individuals by plan type, to determine the current average payment rate one also needs to account for utilization differences. We used data from the GMCB about all hospitals' payer mix in the state to determine that Medicare currently accounts for 38 percent of patients, Medicaid accounts for 16 percent, and commercial plans account the remaining 46 percent of patients. Overall, these numbers indicate the current average effective payment rate for hospitals in the state is 122 percent of Medicare. However, applying the assumed 105 percent rate used in the Financing Plan, the average yield would fall to 103 percent overall (Table 3).

[2] Medicare Payment and Advisory Commission. "Report to the Congress: Medicare Payment Policy". March 2013.
[3] Green Mountain Care Board is a regulatory body that oversees many aspects of health care in Vermont. It was created well before the passage of Act 48 and its name does not mean that it is responsible for the future program called Green Mountain Care.
[4] Green Mountain Care Board. "Vermont Hospital Cost Shift Report". April, 2013. Available at http://gmcboard.vermont.gov/sites/gmcboard/files/CostShift2013.pdf.

Table 3: Estimated Average Payment Yield at Vermont Hospitals, 2012 and 2017E

Coverage Group	Coverage Mix	Patient Mix	Yield as Percent of Medicare Rate	
			2012	2017E (GMC)
Commercial	59%	46%	155%	105%
Medicaid	21%	16%	82%	105%
Medicare	20%	38%	100%	100%
Average			**122%**	**103%**

Source: Financing Plan & GMCB "Vermont Community Hospitals Financial and Statistical Trends Fiscal Year 2012 Actuals"
Note: we have included the uninsured with Medicaid; this assumes that the mix of uninsured who pay full charges and the mix who do not pay anything equate to the same average reimbursement as Medicaid.

As mentioned earlier, State officials we interviewed told us the assumption about provider payment will be subject to discussions with stakeholders. Nevertheless, the State has used the assumption of paying providers at 105 percent of Medicare in several published reports, most notably the recent Medicaid waiver extension that it filed with the U.S. Department of Health and Human Services. In that filing, the State said that it expected providers would be paid at 105 percent of Medicare rates in the Medicaid program starting in 2017 "to eliminate historical cost shifting."[5]

Distributive impact of these payment changes is unclear. In addition to lowering the overall payment for hospitals in the state markedly, applying the same Medicare benchmark to all hospitals could affect each of Vermont's 14 hospitals quite differently.

Each hospital in the state has a different payment-to-cost ratio. A recent report on Vermont hospitals found that, excluding Medicare payments, commercial and Medicaid payments ranged from 36 percent higher than average to 17 percent below average. The same report found that hospitals with higher than average payments also had higher than average costs. The GMCB's most recent report on these hospitals demonstrates that many of the hospitals with higher than average payments already have negative operating margins.

Normalizing all payment ratios across the state to Medicare rates would likely result in some hospitals shutting down service lines due to substantial declines in profitability.

[5] State of Vermont Agency of Human Services. "Global Commitment to Health Section 1115(a) Demonstration Wavier Extension Request to CMS". 11-W-00194/1. Dated May 17, 2013.

Table 4: Vermont Hospitals Payment Variation and Operating Margin

Hospital	Hospital Payments Relative to State Average	Hospital Costs Relative to State Average	Average Operating Margin, FY 2012
Brattleboro Memorial Hospital	-3%	-5%	5.3%
Central Vermont Hospital	-7%	-12%	3.1%
Copley Hospital	13%	1%	0.2%
Fletcher Allen Health Care	-4%	5%	3.4%
Gifford Medical Center	14%	-2%	2.6%
Grace Cottage Hospital	-17%	8%	-8.9%
Mount Ascutney Hospital	36%	76%	-10.0%
North Country Hospital	-9%	-20%	-1.8%
Northeastern VT Regional Hospital	-7%	-33%	3.2%
Northwestern Medical Center	-8%	-8%	9.0%
Porter Medical Center	15%	17%	-9.8%
Rutland Regional Medical Center	16%	10%	-0.1%
Southwestern Vermont Medical Center	1%	-18%	3.3%
Springfield Hospital	-6%	-10%	1.0%
Medicaid-only	**-23%**	**-2%**	
Commercial-only	**20%**	**1%**	

Source: Vermont Association of Hospitals and Health Systems-Network Services Organization. "Vermont Health Systems Payment Variation Report, Phase 1 Draft Report". June 2013; GMCB "Vermont Community Hospitals Financial and Statistical Trends Fiscal Year 2012 Actuals"

Providers currently paid on the basis of costs will need to be considered in determining the payment policy. Vermont has eight Critical Access Hospitals (CAHs). CAHs are rural community hospitals that receive cost-based reimbursement, meaning they are paid for the costs they actually incur. Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act. FQHCs are "safety net" providers of outpatient care such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless.

Generally, Medicare pays FQHCs (which are considered suppliers of Medicare services) an all-inclusive per visit payment amount based on reasonable costs as reported on its annual cost report. It is important for the State to consider how such providers will fit into the GMC payment structure. It is unclear whether the Financing Plan assumes that these providers will be paid at cost or if their rates also reflect the 105 percent of Medicare structure.

Effects of change in payment rates on physicians and other providers even less clear. While the State collects a variety of data on hospital payments and costs, there is less detail regarding the cost structure for physicians and other providers. Part of this is due to the nature of physician offices; for an independent physician, his or her 'operating margin' is actually the

take-home salary. Hospital-employed physicians, on the other hand, rely on relatively healthy hospital margins to support their compensation. Already in Vermont, a large percentage of physicians have migrated to hospital employment due to the financial strains of running a private practice.

A shift in payment to Medicare-linked levels could have similar adverse redistributive effects on physicians in the state, although the exact effect is difficult to determine. Medicare pays physician and other health professionals using a set fee schedule. Under current law, the fees are governed by a sustainable growth rate (SGR) formula that, left unadjusted, would cut physician fees considerably. This SGR formula has called for a cut in physician reimbursement every year since 2002, and with the exception of that first year, Congress has intervened to prevent the mandated cut. Most recently, an estimated 27 percent payment cut to Medicare's physician fees under the SGR was overridden until the end of calendar year 2013.[6] If Congress ever fails to act and prevent the SGR cut and physician payment in Vermont is tied to Medicare, Vermont physicians in GMC could face serious cuts in the future.

Act 48 directs GMC to consider payment reform to modify the method of payment from fee-for-service to one or more alternative methods. While the Financing Plan illustrates the impact of setting provider payment rates at 105 percent of Medicare payment rates, it does not specify what form payment will actually take. Nor does it assume that changes to the structure of payments will alter the trend in health spending. The ultimate payment methodology is to be determined over the next several years.

Vermont has already started implementing new payment models, including the expansive Blueprint for Health primary-care medical homes (PCMHs), various accountable care organizations (ACOs), Medicare bundled payment initiatives, the St. Johnsbury Oncology pilot, and other new models of health care delivery and payment. The results from the emerging reform programs should inform the development of a future payment structure in Vermont.

C. Slower than expected growth in utilization of health care spending due to Vermont-specific reforms could compound provider operating issues with reduced payment

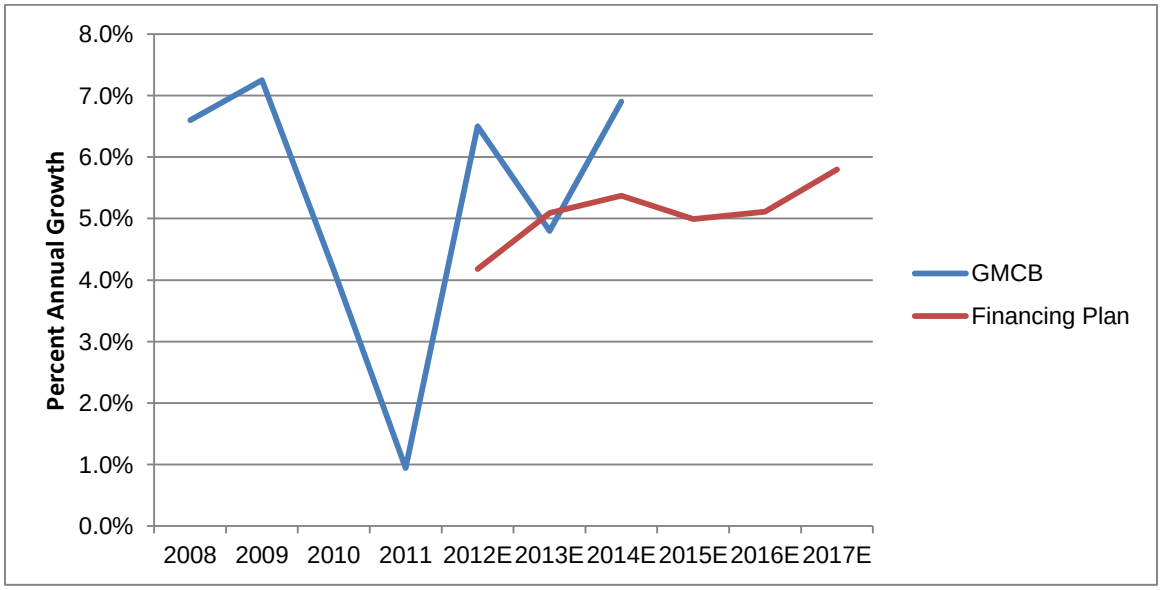
The Financing plan assumes that the GMC plan offered to Vermont residents will have an actuarial value level of 87 percent and that adult dental, adult vision, and comprehensive long-term services and supports will not be benefits covered by GMC in the base plan. Given this design baseline, the Financing Plan forecasts spending from 2011 to 2017 using data from sources such as the Medicare Trustees Report, National Health Expenditure Projections, and state Medicaid data. Much of this data is developed by actuaries who are not looking just at Vermont, and do not include projections of the potential effects of state-based reforms.

[6] Medicare Payment and Advisory Commission. "Report to the Congress: Medicare Payment Policy". March 2013

A national debate has emerged over the past several months regarding the expected growth rate for health care over the next several years and the possible effect of delivery reforms. One camp believes payment reforms will have a lasting effect, leading to lower growth rates despite an increase in coverage.[7] A separate camp believes the recent slowdown in the national spending trend is more directly tied to the broad economy, and that rates will climb as the economy regains strength.[8] Most actuaries, in projecting future cost growth, do not give significant credit to reform efforts, given the dearth of solid evidence on the effects of these reforms.

Health care utilization in Vermont slowed down significantly during the 2010-2011 period. On a per capita basis, the annual growth rate for total health care costs in Vermont dropped significantly from 7-8 percent per year in 2008 and 2009 to 4.2 percent in 2010 and 0.9 percent in 2011. The GMCB estimates per capita spending will return to much higher levels in 2012-2014, and the Financing Plan uses similar assumptions to forecast per capita spending rates through 2017.

Figure 1: Historical and Estimated Per Capita Health Care Costs, 2008-2017

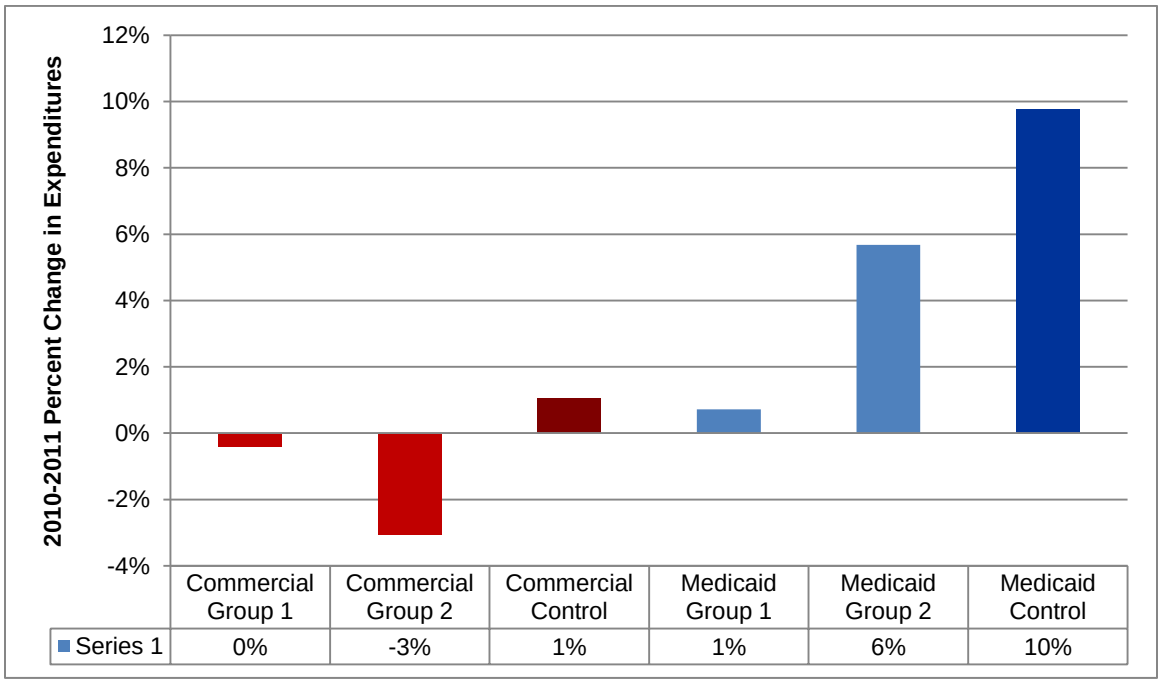


Source: Financing Plan & 2011 Vermont Health Care Expenditure Analysis

[7] Cutler, David and Nikhil Sahni. "If Slow Growth of Health Care Persists, Projections May Be Off By $770 Billion". *Health Affairs* 2013: 32(5); 841-850.
[8] Kaiser Family Foundation. "Assessing the Effects of the Economy on the Recent Slowdown in Health Spending". April 22, 2013. Available online at http://kff.org/health-costs/issue-brief/assessing-the-effects-of-the-economy-on-the-recent-slowdown-in-health-spending-2/.

The PCMHs operating in the Blueprint for Health have started to see some limited success among commercial and Medicaid patients. While still early, the results shown in the 2012 Annual Report[9] suggest that efforts to target high-cost individuals might succeed in slowing down the overall utilization rate. The two Medicaid groups enrolled in Blueprint programs grew at a slower rate than the non-Blueprint group, while the two commercial groups in Blueprint actually saw declines in total costs.

Figure 2: 2010-2011 Growth for Blueprint for Health Groups versus Non-Blueprint Groups



Source: Vermont Blueprint for Health, 2012 Annual Report

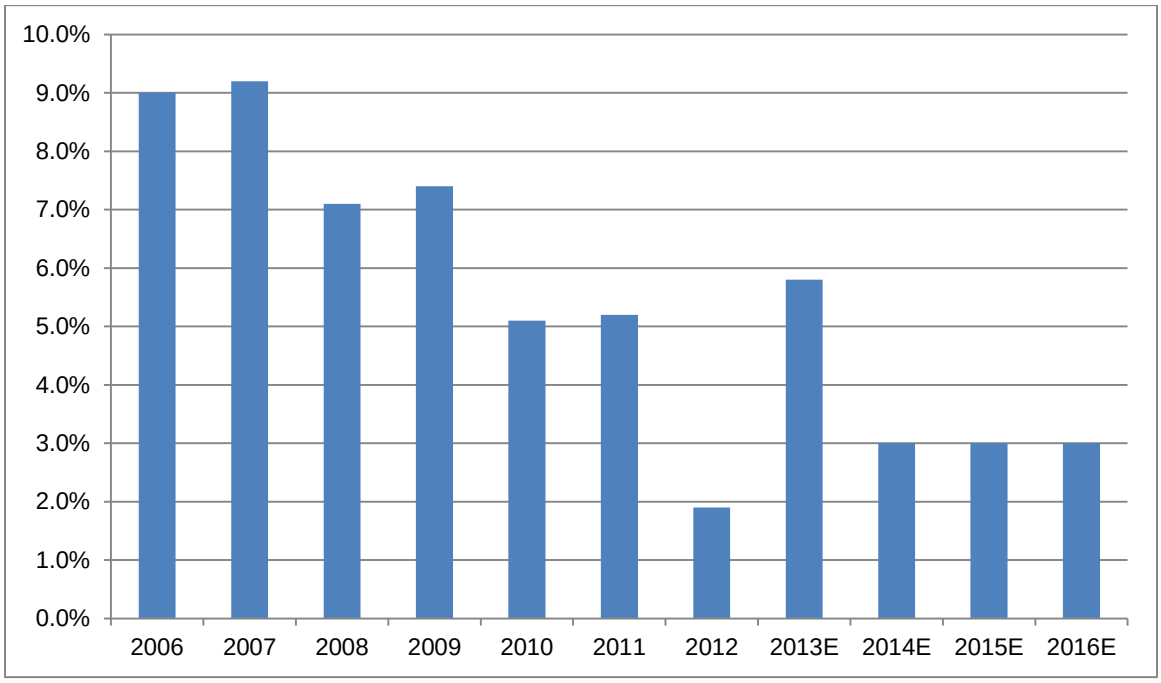
Building on these efforts, in February 2013, Vermont received a $45 million grant under the federal government's State Innovation Models (SIM) initiative to support health care innovations, including three provider payment models: 1) shared savings accountable care payments, 2) bundled payments, and 3) pay-for-performance models. The State's description of the initiative says the grant will support investments in Vermont's health system infrastructure, including improvements that will help facilitate data exchange and integration across providers and the use of telemedicine.

In addition to the delivery reform activities, there has been increasing regulatory pressure on hospitals to reduce spending. The GMCB is responsible for approving budgets for all hospitals in Vermont. In recent years, the hospital budget review has focused on containing hospital cost

[9] Department of Vermont Health Access. "Vermont Blueprint for Health, 2012 Annual Report". February 15, 2013.

growth by limiting both annual payment increases and net patient revenue increases. According to data from the GMCB, growth in hospital net revenues declined from approximately 7-9 percent per year in 2006-2009 to 5 percent in each of 2010 and 2011, and then further to 1.9 percent in 2012. Building on the recent experience, the GMCB established a revenue growth target for hospitals at 3 percent per year from 2014 to 2016.

Figure 3: Historical and Budgeted Net Revenue Growth at Vermont Hospitals



Source: Green Mountain Care Board

As noted above, there remains considerable uncertainty regarding the effects of reform models on spending growth. There is also a continuing debate about the underlying secular growth rate for health care. What is known about slower growth in utilization is it tends to negatively affect providers' operating margins, given the relatively fixed costs associated with many types of providers.

If either secular trends or specific reforms should produce lower cost growth than used by the authors of the Financing Plan, and the State shifts reimbursement to 105 percent of Medicare, the actual amount of reduced provider payments relative to the expectations in the Financing Plan could be much greater. While this may allow Vermont to adjust provider payment less drastically, providers would still be operating in an environment of diminished aggregate revenue.

D. While reducing administrative cost savings represents an attractive opportunity for GMC, the Financing Plan's estimates seem too aggressive

The Financing Plan projects total administrative cost for payers to decline by $126 million, a supposed mid-range estimate, reducing the financing cost for GMC. On the other hand, the expected administrative savings amount for hospitals and physicians, $153 million, is presumed to accrue to providers and therefore is not reflected as a GMC cost offset in the Financing Plan.

The estimated current administrative cost ratio for payers might be too high. The Financing Plan estimates that, by moving most Vermont residents from a number of private payers to one public payer, administrative costs can be reduced by approximately $126 million, with a range of $39.1-$211.3 million depending on the specific savings assumption used. These estimates, however, start with an assumption that the weighted average private insurer administrative costs as a percentage of total spending was 11.9 percent, relying on a report from December 2009.[10]

More recent estimates from the GMCB suggest that the average administrative ratio for private plans in Vermont for 2013 is 6.7 percent, a result of efforts by the GMCB and the insurers themselves to control health plan costs. One of the primary drivers of this decline in the administrative cost ratio is the growth in enrollment and low increases in operating costs for Blue Cross Blue Shield of Vermont (BCBS-VT), the state's largest private insurer. As BCBS-VT continues to gain market share, its below-average administrative ratio will likely continue to lower the average cost of administration for insurers operating in the state.

Table 5: Private Carrier Administrative Costs Already Below Financing Plan Target

Commercial insurer	2011	2012	2013**
Covered lives			
MVP	35,460	29,871	26,204
BCBS-VT	97,386	116,977	130,579
TVHP*	39,023	40,241	34,151
Total	**171,869**	**187,089**	**190,934**
Administrative costs as a percentage of premiums			
MVP	16.9%	15.1%	15.0%
BCBS-VT	5.0%	5.0%	4.3%
TVHP*	12.3%	10.9%	11.2%
Total Average	**8.7%**	**7.5%**	**6.7%**

Source: GMCB Carriers' Administrative Costs, accessed July 10, 2013
*TVHP is a subsidiary of BCBS-VT
** All figures for 2013 were projections. BCBS-VT's enrollment is actually much greater.

[10] Vermont Department of Banking, Insurance, Securities and health Care Administration. "Health Plan Administrative Cost Report." December 2009.

Since private insurance has already reduced the administrative margin to levels below the mid-point target in the Financing Plan, it may not be feasible for the state-run program to achieve additional savings.

For providers, reducing administrative costs relies on reducing labor costs, which may not be feasible. As the Financing Plan notes, the bulk of administrative costs for providers is related to dealing with payers. As such, the Financing Plan uses published studies regarding the effect of a single-payer market to estimate the savings that could be found from reducing the number of payers in Vermont. At the core of this assumption is that these administrative costs are linear: if 50 percent of enrollment shifts into a single plan, then 50 percent of administrative costs related to dealing with payers could be eliminated.

However, there are two factors that we believe were not fully considered in the Financing Plan:

- **Payer market is already consolidated**: Vermont has only three major commercial health insurers - Blue Cross Blue Shield of Vermont, Cigna, and MVP. Based on a report by the Vermont Legislative Joint Fiscal Office (JFO) and the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA),[11] billing and insurance related activities for the state's largest provider, Fletcher Allen Health Care, represented only 4 percent of its total costs. This is significantly lower than the Financing Plan's assumption, which is estimated to be 6.6 percent of revenue. While eliminating one or two payers may result in some simplification, it is difficult to imagine that one-third to two-thirds of such costs could be eliminated. Vermont providers will still have to deal with a number of other non-GMC insurance plans, including Medicare, multiple Federal Employees Health Benefits Plan (FEHPB) insurers, commercial insurers covering employer plans outside of the GMC, and non-Vermont residents who receive health care services from Vermont-based providers.
- **Administrative costs are personnel costs:** The nature of administrative costs for most providers is realized in labor expense. Providers employ personnel to complete claims forms, connect with insurers to work through billing issues, and obtain prior approval for medical procedures, among other administrative functions. In the short term, these costs are essentially fixed, as the staff is still needed to deal with the remaining administrative tasks. As one interviewee noted, providers may be able to shift the responsibilities for these employees to patient-facing duties; however, shifting staff responsibilities would not result in lower total costs, but rather simply a reallocation of existing costs.

[11] Costs of Vermont's Health Care System Comparison of Baseline and Reformed System, Final Report, November 1, 2011

III. Financing Plan Gaps

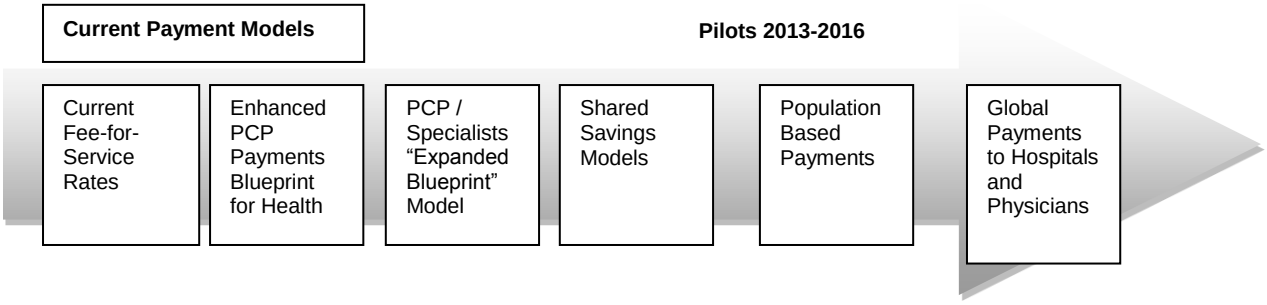
The Financing Plan does not address or resolve some key concepts or questions. In this section we outline some of the gaps in the Financing Plan that will need bridging before GMC is to be activated.

A. How payments will actually be made under the reform plan is not specified

Payment rate design is one of the core questions posed by constituents in the state. While the Financing Plan illustrates the impact of setting the payment rate at 105 percent of Medicare payment rates, most of the provider groups do not consider this level of reimbursement to be a sustainable payment methodology. State officials noted in meetings that the Financing Plan uses this assumption as a starting point. They say that the ultimate payment formula could differ in both structure and amounts. However, the reimbursement rate of 105 percent of Medicare is one of the key assumptions used in determining the Financing Plan's $1.61 billion revenue need and, as noted earlier, the State has used this assumption in other formal documents.

Act 48 directs GMC to consider payment reform to modify the method of payment from a fee-for-service basis to one or more alternative methods. While Vermont is still in the early stages of testing the various delivery and payment models, based on the outline provided by the State, the goal for 2017 is to replace the current fee-for-service payment system with global payments to hospitals and physicians.

Figure 4: Payment Reform Model Timeline



Source: Health Care Reform in Vermont, Presentation to HFMA Region 1 Annual Conference, May 16, 2013

These new payment models will need to be defined more clearly. In our experience, payment systems must be designed to make sure that risks are fully understood and that financial performance of the risk-bearing entity is actually within its control. Moreover, providers need to deploy new tools and to learn new behaviors when they take on risk that traditionally has been

held by insurers. Without additional clarity regarding the specific payment structure, it is difficult to assume that the cost for GMC has been accounted for in its entirety.

B. Out-of-State Care: Impact on GMC Payment Rate and Administrative Costs

The Financing Plan assumes that Vermont will be able to negotiate consistent payment rates as a percentage of the Medicare payment schedule for approximately 90 percent of the current commercial medical claims. This assumption is based on the expectation that the following percentages of medical claim costs will be able to be negotiated: 100 percent of Vermont costs, 75 percent of costs from neighboring states, and 0 percent of costs from all other states.

Looking at commercial claims data for Vermont residents from 2011, about one-quarter of the commercial payments were made to providers located outside of Vermont. New Hampshire has the largest share of out-of-state claims. The vast majority of the inpatient discharges from New Hampshire come from the Dartmouth Hitchcock Medical Center.[12]

Depending on GMC's success in negotiating payment rates with the key providers, the out-of-state provider payment rates under GMC could be higher or lower than the Financing Plan's assumption. The Financing Plan's assumption that GMC will be able to negotiate rates on 75 percent of the medical costs from neighboring states seems to be aggressive without assuming GMC will access an existing health plan's contracted provider network. And if GMC is to access such a network, it will likely pay a fee to do so. No such fee is mentioned in the Financing Plan.

Table 6: 2011 Commercial Claim Payments for Vermont Residents by Location of Provider

State of Provider	Inpatient	Outpatient	Other Facilities	Professional	Home/ Ambulatory/ DME	Pharmacy	Total
VT	67%	78%	60%	76%	45%	73%	**74%**
NH	22%	18%	23%	14%	10%	3%	**17%**
MA	6%	3%	61%	0%	36%	9%	**3%**
NY	2%	0%	2%	2%	12%	1%	**1%**
FL	0%	0%	3%	1%	3%	1%	**0%**
Other	3%	1%	10%	5%	27%	15%	**4%**

Source: Email correspondence from Steven Kappel

Also, based on the Financing Plan's assumption, it is not clear how out-of-state services affect the administrative cost under GMC. GMC will need to contract with out-of-state providers, while

[12] 2011 Vermont Health Care Expenditure Analysis, Green Mountain Care Board, April, 2013

providers in Vermont will continue to see patients from other states who have a variety of medical coverage sources.

IV. Stakeholder Impact Analysis

The Financing Plan has profound implications for many Vermont stakeholders, including providers, payers, employers, and consumers. In this section we appraise the Financing Plan's impact on each of these groups.

A. Providers

The Financing Plan raises a number of questions for providers. Among key topics are: 1) the impact GMC will have on Vermont's health care workforce; 2) the effect GMC will have on Vermont providers delivering care to patients not covered by GMC; and 3) the ability of providers to sustain their operations under the proposed payment framework.

The Financing Plan could greatly affect the health care workforce in the state. In its current form, the Financing Plan proposes to pay providers at 105 percent of Medicare rates, which we have noted amounts to a deep cut in average payment rates. The Financing Plan assumes that the growth in covered lives and reduction in administrative costs will help offset the decrease in average provider payment rates. However, providers' administrative costs may not come down as anticipated, and the assumed conversion of uninsured to insured patients may not fully offset the reduction in payment rates.

Given this, it may become challenging for Vermont to retain a highly qualified and talented health care workforce and to attract new highly qualified health care professionals. The State produced a Healthcare Workforce Strategic Plan in accordance with Act 48 (Section 12a) to help address issues related to workforce planning, recruitment, and retention under GMC. Although the Healthcare Workforce Strategic Plan recommends actions the GMC Board should take in developing a health care workforce under GMC, neither the Healthcare Workforce Strategic Plan nor the Financing Plan speculate upon GMC's impact on the health care workforce should the economics of practicing in Vermont become more challenging.

B. Payers

The underlying goal of GMC in 2017 is for Vermont to transition to a single-payer system. The Financing Plan plainly lays out this assumption: "GMC will provide the administrative functions currently performed separately by each private and public health plan through a unified system."

When we asked State officials if this statement means that health insurers would cease to function in Vermont, they confirmed that insurers would not be needed with respect to Vermont residents covered by GMC. They suggested that they intend to explore alternative roles and/or services existing health insurance carriers may be able to perform under a single-payer system.

Vermont is served primarily by three commercial health insurers, and the impact of GMC on each one would likely vary:

- MVP Health Care is a regional health plan serving upstate New York, Vermont and New Hampshire, with about 500,000 people enrolled in its medical insurance products. Of those, approximately 26,000 (5 percent) are Vermont residents. The loss of most of its Vermont enrollees would result in a significant reduction in operating earnings. Market forces already cost MVP about 13 percent of its enrollment in 2012.
- Cigna is a global company (2012 revenues: $29 billion) that does not depend on Vermont business – approximately 60,000 of its roughly 13 million U.S. medical lives are in the state. Also, a large fraction of Cigna's business is with self-insured employers who, as noted earlier, might exempt themselves from GMC. So Cigna as a corporation would not notice much impact.
- Blue Cross Blue Shield of Vermont relies almost exclusively upon providing health insurance and related services to Vermont residents.[13] With approximately 220,000 enrollees, it covers more than 70 percent of the privately insured people in the state. If GMC actually captures the population expected by the Financing Plan, it is very possible that BCBS-VT would go out of business. At minimum, the company would shrink significantly and it would have to alter its business model radically.

The elimination of private health insurers in Vermont – in particular, Blue Cross Blue Shield of Vermont, the only payer operating entirely in the state – could result in the loss of a significant number jobs in the state.

C. Employers

The local employers we spoke with were cautiously hopeful that GMC might unburden them of the ever-rising expense of providing health care coverage to their workers. Yet the Financing Plan does not say whether employers will be expected to help with the funding of GMC through an employment-based tax such as a payroll tax, or if funding will come from more diverse sources such as an income tax or other assessments. This uncertainty makes it difficult for employers to fully understand what the impact GMC will be for them.

[13] Each Blue Cross Blue Shield plan is an independent company licensed to use the name and trademarks by the national Blue Cross Blue Shield Association. The Vermont plan is not a unit of a larger corporation,

Although employers' roles in GMC have not been clearly defined yet, it can be inferred that GMC may have positive or negative effects on an employer depending on the company's size, location, and insurance status. For instance, GMC may be favorable for smaller companies that are solely based in Vermont and pay high health care premiums today. Such organizations could save money if the responsibility for insuring workers for health costs shifted to GMC. Again, though, the savings depends entirely on the financing mechanism used to pay for GMC.

In contrast, GMC may be unfavorable for large employers that operate in multiple states and self-insure for employee health care coverage. Such organizations cannot be required to participate in GMC as they are governed by the federal ERISA law, though they may still be called upon to help fund GMC since they conduct business in Vermont. This will create a significant disincentive for such organizations to continue doing business in Vermont. At minimum, these employers might seek exemption from any payroll tax meant to fund GMC, which could leave other employers or taxpayers shouldering a larger burden.

D. Consumers

According to the Financing Plan, a large proportion of Vermont residents will be covered by GMC, if not as primary insurer then as a source of secondary, or supplemental, coverage.

By furnishing coverage at 87 percent actuarial value, GMC will reduce cost-sharing for many consumers. This will eliminate a key barrier to health care access, yet consumers may experience longer wait times to receive health care services due to the increased volumes of patients. Access to care could be constrained further if the supply of health care practitioners and facilities is diminished as a result of reduced payment.

Consumers may be affected by additional taxes that are administered in the state to help with the financing of GMC. The changes from today will vary markedly for individual consumers depending on their income levels – which could matter if an income-based tax is established to finance the program – and how much they pay toward premiums and in out-of-pocket costs now.