Act 128 & Act 48 Report Overviews
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Hsiao Report Overview *(Act 128 of 2010)*
Report Released January 2011

NOTE: Keep in mind, that while the Affordable Care Act had passed, at the time much of the details and potential impacts were not yet known.

Charged with coming up with three options

1) Government-run Single Payer system
2) Public Option
3) Public-Private Single Payer *(Report recommend option 3)*
   - Essential health benefits package
   - Limited vision and dental (if enough savings)
   - Excluded long-term care
   - Medicaid and Medicare benefits would not change
   - Includes workers compensation
   - Governed by an independent board with representation from the major health care payers (employers, the state, workers) along with beneficiaries and consumers.
   - Contract out provider relations and claims administration

Design parameters

- Models assumed that single-payer would be implemented in 2015
- Lock-in federal funds for Vermont
- No overall increase in health spending – funds needed would have to come from savings
- No overall increase of spending for employers and workers (financing)
- No reduction in overall net income for physicians, hospitals and other providers
- Payment method change as the strategic entry point to establish integrated delivery.
- No change for Medicare beneficiaries

Structural Components

- Change to a single-payer system to reduce:
  - Administrative costs
  - Waste in health care delivery
- Tort reform
- Blueprint and medical homes
- Financing – introduce payroll tax contribution
- Payment – incentive structure for providers
- Change in delivery system – ACOs, integrate delivery
- Regulations

***Estimated savings* under proposals**

The Act 128 report estimated accumulated savings between 16.1% and 25.3% depending on the option (option 1, option 2, or option 3). *Assumed single-payer would be implemented in 2015.*

Savings Estimations (excluding Medicare savings)

	Percent of total health spending from 2015 to 2024	Absolute savings in 2010 Dollars		
		2015	2019	2024
Option 1	24.3%	$530 million	$1,280 million	$2,000 million
Option 2	16.1%	$330 million	$870 million	$1,300 million
Option 3	25.3%	$590 million	$1,350 million	$2,100 million

Margin of Error ± 15%

***Identified sources of savings* under proposals**

- *At the time, the report admitted there was uncertainty around the assumptions and estimates. Since there is little to no experience with this type of system domestically, much of the assumptions rely on empirical evidence from peer-reviewed journals.*
- *It should also be noted that some of the estimated savings would accrue immediately while others would accrue over time.*
- *Dr. Hsiao also cautioned that the saving approaches are not necessarily a "menu" of savings options. While some of the initiatives, if not implemented will yield less savings (i.e. Medical Malpractice), others are fundamental to the underlying plan (i.e. integrated delivery reform).*

Table 2: Accumulated savings by source as percent of total health expenditure over the 2015-2024 period.

	Option 1 Savings	Option 2 Savings	Option 3 Savings
Administrative - Insurer & Provider	7.3%	3.6%	7.8%
Reduced Fraud and Abuse	5%	5%	5%
Shift to Integrated Delivery System	10%	5.5%	10%
Medical Malpractice Reform	2%	2%	2%
Management Structure	-	-	0.5%
Total Savings	**24.3%**	**16.1%**	**25.3%**

1) *Administrative savings*

- Insurer administrative costs
  - Insurance functions - reduction of need for marketing, sales, underwriting, etc.
  - Provider relations – less time spent on things such as negotiating provider payments, etc.
  - Claims payment activities – decreased costs in claims administration such as claims review, authorization, adjudication, auditing, etc.
  - Recommended moving to an electronic system of claims recording and the issuance of smart cards for processing purposes.

- Provider administrative costs
  - Direct – reductions in time spent on billing and collection from multiple payers, verifying insurance, dealing with drug formularies, seeking prior authorization, collecting varied cost-shares, etc.
  - Indirect – Fewer staff needed to handle payer matters due to simplification.

2) *Savings from Fraud and abuse*

- According to the report, under a single payer plan it should be easier to implement a comprehensive state level all-claims database for fraud and abuse protection.

3) *Integrated delivery system, the Blueprint, and medical homes*

4) *Tort Reform*

- Recommended moving to a no-fault medical malpractice system.
- Savings would stem from changes to medical practice patterns resulting from less defensive medicine.

Use of savings under proposals

- Cover remaining uninsured
- Bring all Vermonters up to standard, essential benefit package
- Provide some additional vision and dental coverage for all Vermonters
- $50 million for increased supply of primary care workforce and upgrades of community hospitals

Dr. Hsiao Recommended Option 3.

Table B. Recommended Use of Savings under the Different Benefits Packages.

Benefits package	2016 Standard (Options 1B and 3)	2016 Comprehensive (Option 1 A)	2019 Standard (Options 1B and 3)	2019 Comprehensive (Option 1A)
Coverage of the uninsured	$227 million	$260 million	$250 million	$285 million
Increased benefits for the underinsured	$33 million	$333 million	$36 million	$366 million
Investments in primary care and community hospitals	$64 million	$64 million	$70 million	$70 million
Additional dental and vision benefits	$128 million	$377 million	$140 million	$415 million
Long-term care benefits	-	$204 million	-	$225 million
Savings from uniform payment rate	($57 million)	($57 million)	($63 million)	($63 million)
Total	**$395 million**	**$1,180 million**	**$435 million**	**$1,300 million**

Note: All dollar figures are expressed in real 2010 dollars.

Financing the proposals

- Payroll contribution
- Exemptions for low wage employers and workers (MORE DETAIL)
- Estimated no additional cost to most employers and workers.

Table 31. Estimated Payroll Contribution Rates as a Percentage of Total Payroll for the Three Reform Options

		No reform[1]	Option 1B Standard	Option 1A Comprehensive	Option 2	Option 3 Standard
Total[2]	**2016**	13.40%	12.80%	18.20%	12.40%	**12.50%**
	2019	13.70%	11.80%	17.10%	13.60%	**11.60%**
Employer Contribution	**2016**	9.30%	9.60%	13.60%	8.50%	**9.40%**
	2019	9.60%	8.80%	12.80%	8.50%	**8.70%**
Employee Contribution	**2016**	4.10%	3.20%	4.60%	3.90%	**3.10%**
	2019	4.10%	3.00%	4.30%	5.10%	**2.90%**

Dr. Hsiao Recommended Option 3.

Payment to providers

- Establish uniform payment method and rates for all payers
- Move to capitation plus pay-for-performance wherever possible to promote integrated delivery
- Move towards ACOs

UMASS / Wakely Study (Act 48 of 2011)
Report Released January 2013

*Prepared by **the University of Massachusetts Medical School** – Center for Health Law Economics and **Wakely Consulting Group, Inc**. (Actuarial services)*

Underlying Assumptions

The following are many of the assumptions that provide the foundation for estimating the costs of Green Mountain Care (GMC)

- The report assumes GMC will begin in 2017
- All Vermont residents will be enrolled automatically into GMC (2017)
- GMC will be secondary to any other coverage (such as Medicare, employer-sponsored insurance, etc.)
    - Medicare will cover supplemental and pharmacy up to 87% AV. Part B will only be covered for the dual-eligibles.
- GMC will include mental health & substance abuse services, pharmaceuticals, pediatric dental and vision care, and care coordination for individuals with chronic or complex care needs.
- The report separately estimated the cost of covering adult dental, vision, and long-term care. If added (*see page 44*):
    - Adult Dental:
        - Coverage of preventive and routine = $218M
        - Additional coverage of more major services = $294M
    - Adult Vision = $46M
    - Comprehensive LTC services & supports = $917M
- GMC will have an actuarial value (AV) of 87%. Other AV options (table 38, page, 38):
    - 80% AV = $225M less
    - 100% AV = $631M more
    - These estimates take into consider the concept of induced utilization – that is the idea that consumer behavior changes based on the amount of cost-sharing people are required to pay for health care services. The less they have to pay, the more likely they are to use more health care services.
- Low-income individuals, who are currently eligible for cost-sharing subsidies under the Affordable Care Act (ACA), will have a GMC plan design that reflects the reduced cost-sharing equivalent to those subsidies.
- Model assumes GMC will pay health care providers an average of 105% of Medicare rates. Other options are (table 25, page 37):
    - 100% of Medicare = $113M less
    - 110% of Medicare = $113M more.
- Vermont's population will grow at 0.2% (currently grows at 0.1%)
- Vermont's uninsured rate in 2014 will be 4% (currently around 7%) and will continue to decline to 2% by 2017 (pre-GMC).

    - Under GMC uninsured rate would be 0% if everyone is covered.
- GMC would provide the administrative functions currently performed separately by each private insurance plan.
- 2017 estimates are built on estimate of 2014 (post-exchange).

Migrations Assumptions (to GMC as primary)

The report refers to GMC as primary (primary source of insurance) or secondary (secondary sources of insurance). The following are the reports estimated migration to GMC as primary:

- Medicaid = 100%
- Uninsured = 100%
    - State could receive Medicaid match on 30% of this group
- Individual market = 100%
- Small group market = 70-100%
- State gov't and municipalities = 100%
- Hospital system employees = 80-100%
- National accounts (such as IBM, etc.) = 50-100%
- Other large groups = 50-100%
    - 3% of large group would be eligible for Medicaid
- Federal employees and tri-care = no change
- Report makes no assumptions about people migrating to VT for GMC.
- *TOTAL PRIVATE MARKET = 66-88%*

Cost & funding estimates

NOTE: The numbers below represent the UMASS/Wakely report estimates and do not reflect the more recent consensus JFO/Administration revised estimates ($1.8 – $2.2B)

- The report assumes the state will save $281M in the first 3 years of implementation of GMC.

Table 6. Total estimated statewide health care costs, 2017-2019 (in Millions)

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

- The savings in the chart above assumes some offsets from increases in claims/costs.

Ex. SFY'17 $122M reduction in admin
-$86M increase in claims/costs
$36M savings with Reform

- As shown below, the report assumes much of the funding sources would remain the same with or without GMC (such as Medicaid, Medicare, ACA, etc.). The lion-share of the funding to be newly financed under GMC is a result of the elimination of premium contributions from individuals, employers, and employees.

Table 7. Sources of funds with and without reform, 2017 (Millions of Dollars)

	Without reform	With reform	Difference
Individuals and Employers *	$2,228	$332	($1,896)
Federal: Medicare	$1,613	$1,613	$0
Federal: Medicaid Match	$998	$1,247	$249
Federal: ACA	$267	$267	$0
Federal: Other	$209	$209	$0
State Medicaid Funding	$637	$637	$0
Total Sources of Funds	**$5,952**	**$4,305**	**($1,647)**
Total System Costs	**($5,952)**	**($5,916)**	**$35**
Amount to be Financed		**($1,611)**	**($1,611)**

- Federal participation – Report assumes individual premium tax credits and cost-sharing subsidies would be passed through to the state under GMC (approx. $267M).
- The state would not only continue to get federal matching through the Medicaid Waiver, but could potentially receive $249M more in a "reformed" system.
- The report does not recommend a specific funding source (or combination of sources) to fund GMC. It does however offer two charts of estimated revenues (table 47, page 70) and tax expenditures (table 48, page 71)

Administrative Savings

- Under the current health care system, payers and providers spend a significant amount of time and money submitting and processing claims, coordinating benefits, and managing authorization processes. It is assumed that under a single-payer model, the time and dollars spent on these functions will decrease. However, the report admits that it is a challenge to estimate the amounts that could be saved due to such administrative simplifications under GMC.
    - Offsets: Potential costs related to the implementation of GMC are not offset from the savings figures. Providers may need to invest in IT, particularly in the early years, to conform to changes required by single-payer and any related payment and clinical reforms.
- The report focused on potential administrative savings for PAYERS and PROVIDERS (Table 35, pg. 51)

- Payers Savings (Mid-range estimate) = Administration lowered from 11.9% to 7% of premiums
  - *NOTE: The Avalere report contended that the current average administrative ratio for private plans in Vermont may actually already be lower than in the report, reducing the potential savings.*
- Providers Savings
  - While the report included provider savings, it did not actually incorporate these projected savings in the overall estimates.
  - They were however taken into consideration when recommending the provider reimbursement rate (105% of Medicare).

TABLE 35: Summary of Administrative Savings Estimates, at full implementation
In millions

	Payers	Physicians and other providers	Hospitals
Low Estimate	$39.1	$53.4	$23.7
Mid-Range Estimate	$126.1	$92.6	$60.5
High Estimate	$211.3	$179.3	$144.6

Note: Assumes that physician, other provider, and hospital savings are fully achieved in 2020. Payer savings are displayed in 2017 dollars, to be consistent with overall GMC estimates.

- Clinical savings – report does not make any assumptions concerning clinical savings as a result of GMC because of already existing initiatives such as Blueprint for Health, but says "the state should consider these savings in its estimates of statewide total health care costs going forward.

Avalere Health – Evaluation of Vermont Health Care Reform Financing Plan *Report Released November 2013*

Background

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 do an assessment of the Financing Plan's cost estimate and its key assumptions.

The Avalere report estimated that the amount needed to be financed under GMC could be $1.9 - $2.2 billion, or about 20 to 35 percent higher than the $1.61 billion estimated by UMASS, based on the concerns highlighted in their evaluation.

Key Concerns for potentially higher costs identified by Report

The Avalere Report highlights several areas of concerns related to the UMASS report assumptions, the two biggest of which relate to provider rates and administrative savings.

Provider Rates

- The UMASS report proposes paying providers 105% of Medicare on average
  - UMASS reports the estimated current payments average is 107% of Medicare.
  - Also estimated that providers would see administrative savings that make up for the 2% rate reduction (estimated at $155 million).
- Avalere contends Vermont hospitals and physicians currently receive 122% of Medicare on average and that going to an average of 107% of Medicare represents a significant reduction in rates.
- Avalere also says that Medicare rates do not accurately reflect different providers' costs and therefore may not be a reliable benchmark.
- Although the Administration and Partners agree there should be continued assessment of the current level of provider reimbursement (and continue the discussion through workgroups, etc.), at this time there is not yet agreement on what provider reimbursements would/should be under GMC, recognizing that the jurisdiction of establishing provider reimbursement rates falls under the jurisdiction of the GMCB consistent within 18 V.S.A. § 9376(b)(1).

Administrative Savings

- Avalere disagrees with the UMASS Report's assumption around administrative savings for payers
  - The UMASS report assumes payer-side administrative costs would decrease from 12-7% and achieve a savings in 2017 of $126 million.
    - Partner's pointed out that UMASS relied on 2008 data.
  - Avalere contends that BCBSVT average administrative ratio for private plans is already lower than suggested in the UMASS report and therefore the estimated savings may not be achieved.
  - Avalere further recommends that the state reexamine the administrative cost assumptions used in the financing plan, especially given that they are now nearly six years old.

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

NOTE: It should be noted that the Administration and Partners have been working together -- creating several workgroups – to address areas of disagreement with the goal of coming to consensus agreements on estimates.

Administration / Joint Fiscal Office – Updated consensus estimates *February 2014*

The Shumlin Administration and the Legislative Joint Fiscal Office released a memorandum indicating a consensus agreement increasing the anticipated amount to be financed for Green Mountain Care in 2017 from $1.611 billion, as modeled by the UMASS/Wakely, to **$1.766 billion to $2.175 billion**.

The memo can be found on the JFO website:
http://www.leg.state.vt.us/jfo/healthcare/Consensus%20estimates%20for%20Green%20Mountain%20Care.pdf

OTHER SINGLE-PAYERS STUDIES

Ken Thorpe (2006)
Costs and implications of a single payer healthcare model for the state of Vermont

The Lewin Group (2001)
Analysis of the costs and impact of universal health care coverage under a single payer model for the state of Vermont