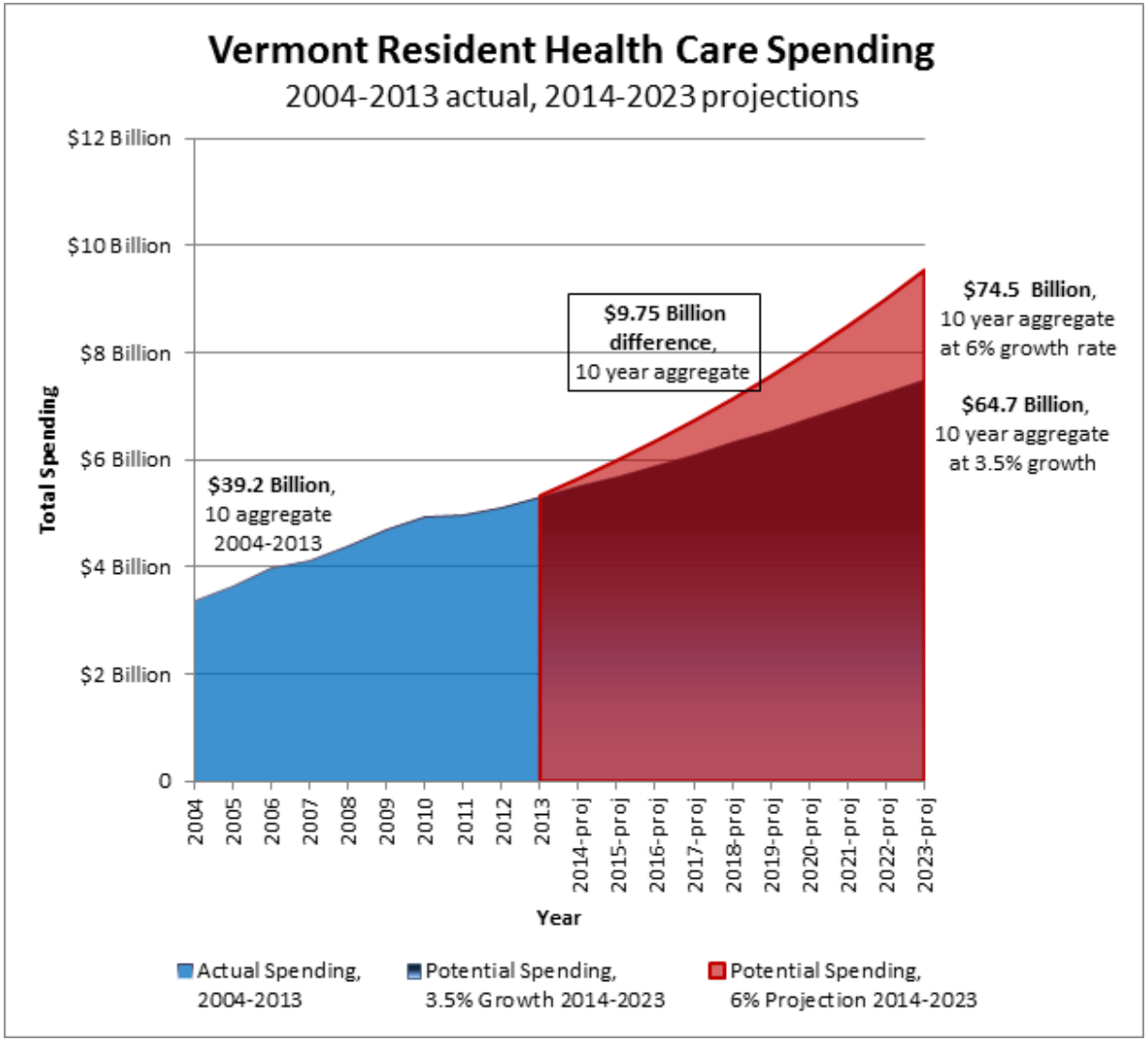
Cost Shift Proposal
Additional Context

Lawrence Miller
Chief of Health Care Reform

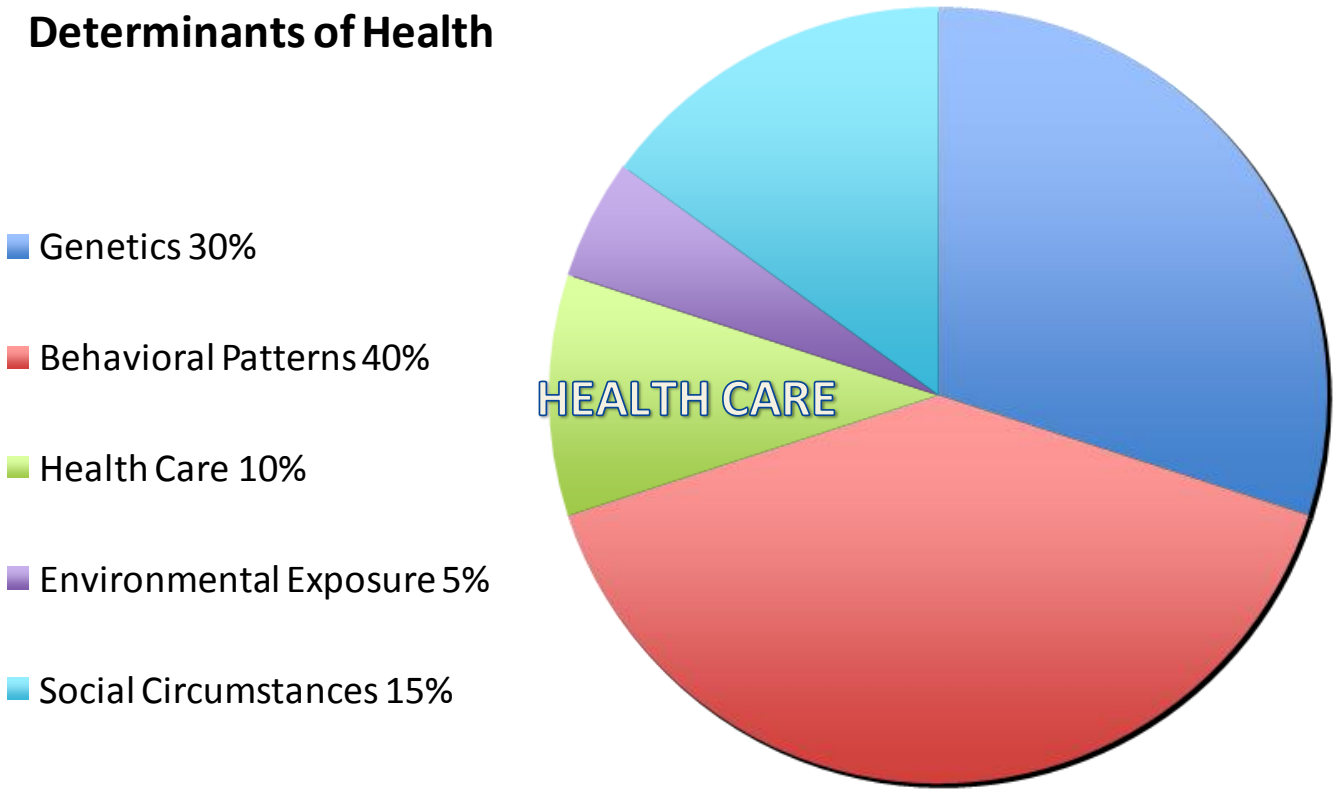
2/11/15

VERMONT
HEALTH CARE REFORM

The Problem: Health Care Costs growing faster than overall inflation



FACTORS INFLUENCING HEALTH STATUS



Adapted from Schroeder, SA. We can do better-Improving the health of the American people. NEJM 2007;357:1221-8

Current System

Misaligned financial incentives across payers and providers has led to **fragmentation** in our medical and social systems.

Linking financing to **value** will fill gaps and strengthen the system

We get what we pay for under a fee-for-service system

A lack of accountability about the range and types of care that patients may receive

Limited payments for coordinating care across clinicians and providers or over time

Limited incentives for improving quality or reducing costs

No incentives for constraining the volume of care


WARNING
Rip Currents
Watch Out!
You could be swept out to sea and drown. If in doubt, don't go out!

Creating a New Plan

- How do we innovate and create a sustainable health care spending trajectory within the ACA?

- Number of ACA policy choices and policies drive state policy:
  - Commits us to thinking inside the employer sponsored insurance box
  - Forces us to consider individual and firm employer behavior given federal mandates, penalties, and taxes
    - Large Employer Penalty
    - Individual Mandate
    - Cadillac Tax

Large Employer Penalty

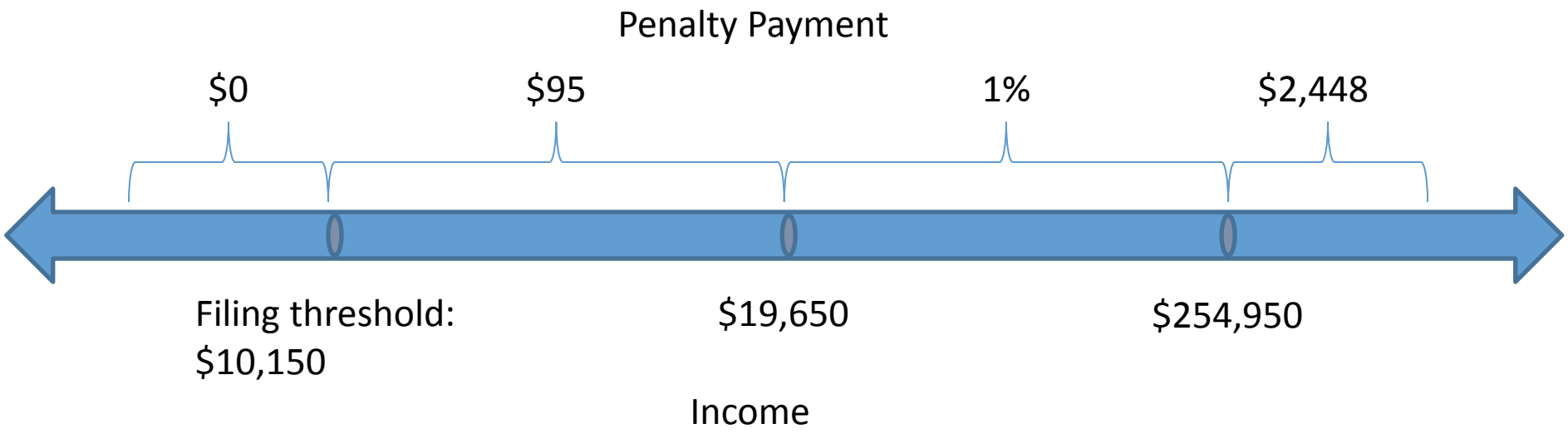
- The federal government tells businesses to pay or play
- Penalty applies to all large employers, including non-profits
- Employer must offer coverage to all dependents
- 2016: Employers with over 50 FTEs subject to federal large employer mandate
  - Must offer coverage to 95% of full-time (30+ hour employees)
- Penalty is complex, but generally fair to say that qualified employers will pay at least $2,000 per uncovered full time employee

Individual Mandate

- Federal policy is for people to have coverage or pay a penalty
- Penalty for lack of coverage without exemption
- In 2014, penalty for those without an exemption is the greater of:
  - $95 per adult and $47.50 per child under age 18 (up to $285 per family)
  - 1% of household income in excess of filing threshold, capped at national average premium for bronze coverage
- Penalty is Capped
  - Maximum amount paid is 1% of income capped at national average premium for bronze coverage. Cap increases with family size.
  - For one individual
    - $204 per individual per month ($2,448 annually)
- For more than one individual
  - the monthly individual amount ($204) is multiplied by the number of individuals subject to a penalty up to a maximum of five individuals.
    - Max $1,020 per month for five or more individuals ($12,240 annually)

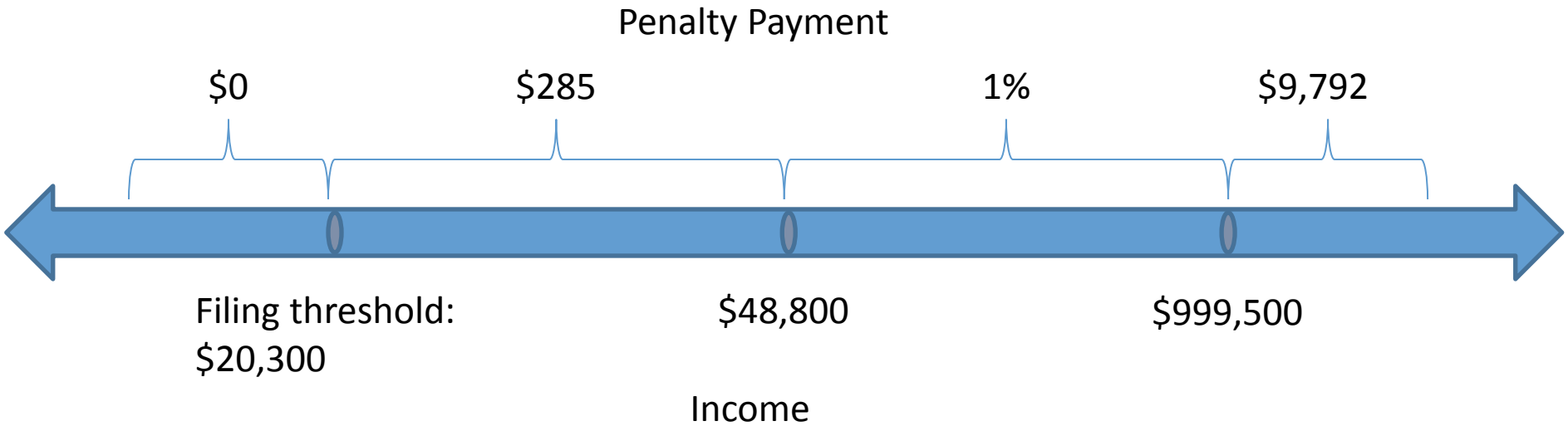
Individual Mandate

2014 Penalty Example– Individual does not have coverage



Individual Mandate

2014 Penalty Example – Family of four does not have coverage



VERMONT
HEALTH CARE REFORM

Cadillac Tax

- Begins in 2018
- 40 percent tax of the value of health coverage exceeding threshold $10,200 individual / $27,500 family
  - Some adjustments made for age, gender and high risk professions
- Indexed for inflation, rounded to the nearest $50
- Applies to both fully-insured and self funded plans, including grandfathered plans
- Federal guidance pending

Strategy

- Hold down premiums while we align medical and behavioral incentives that will reduce costs and achieve quality outcomes
- Play by the current rules of the game (existing Medicaid law and waiver) to maximize VT health care investments in a predictable way
- Adopt revenue policy that gives everyone a stake in holding health care costs down

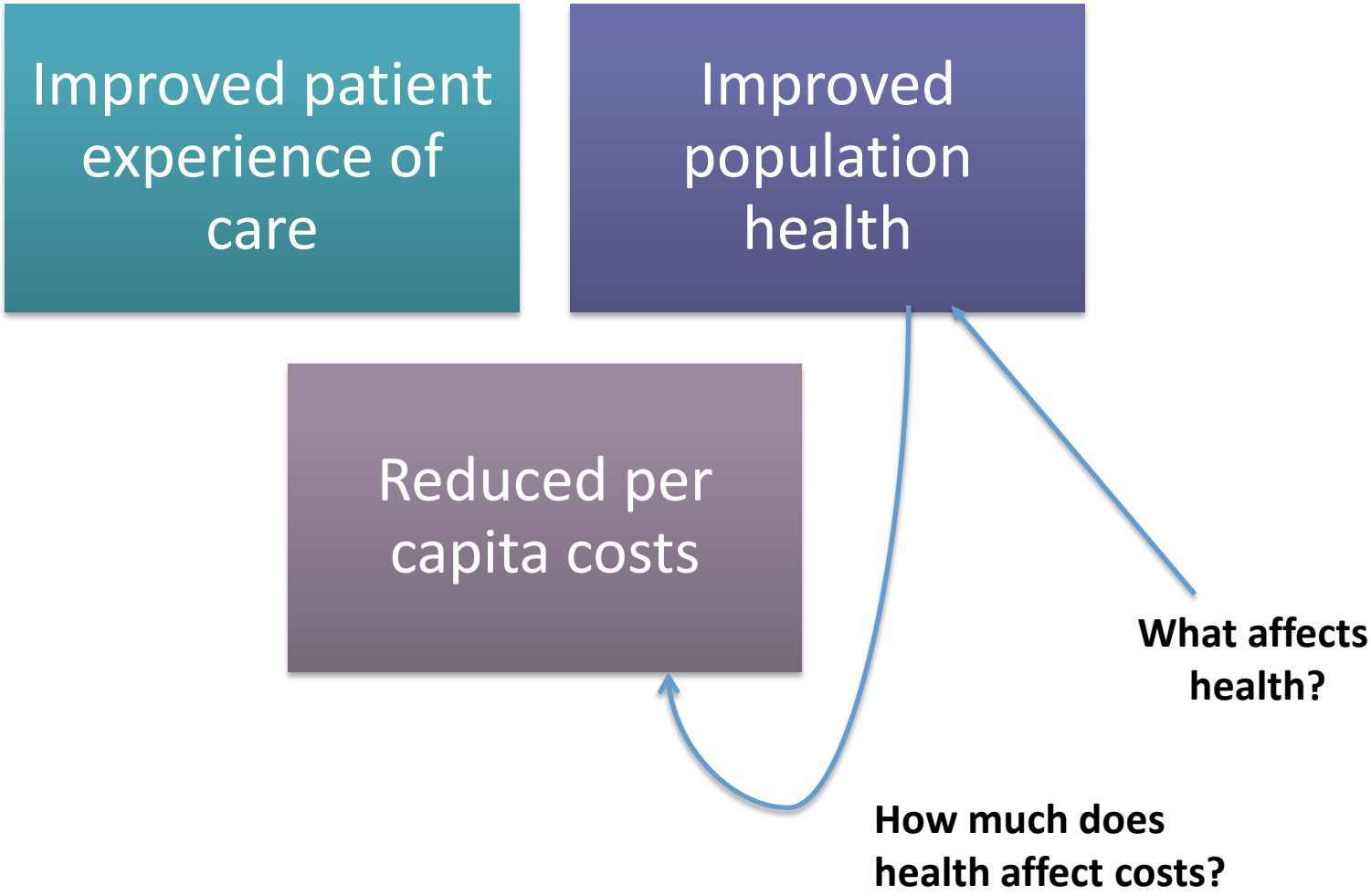
U.S. Health and Human Services Medicare Announcement

- HHS is moving in the direction of shifting Medicare payments from volume to value.
- Pay providers based on quality, rather than the quantity of care they give patients.
- Goal of tying 30% of fee for service Medicare payments to quality or value payment models such as ACOs or bundled payment arrangements by the end of 2016. 50% by end of 2018.
- Goal of tying 85% of all traditional Medicare payments to quality or value by 2016 and 90% by 2018 through programs such as Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.
- This is the first time in the history of Medicare that HHS has set explicit goals for alternative payment models and value based payments.
- http://www.hhs.gov/news/press/2015pres/01/20150126a.html

What is an all-payer model?

- A system of health care provider payment under which all payers – Medicare, Medicaid and commercial insurers such as Blue Cross and Blue Shield – pay doctors, hospitals and other health care providers on a consistent basis, within rules prescribed by a state or national government
- Can be used to promote desirable outcomes and reduce or eliminate cost-shifting between payers
- In the U.S., the only example of an all-payer model is in Maryland (currently only for hospital payments)
- A number of other countries use all-payer systems to assure that provider payments are fair, transparent and consistent with desired policies such as promoting primary care, prevention, quality of care and cost containment

Achieve the “triple aim”



Other Revenue Ideas

- Claims Tax
  - Likely increases premiums since it will be baked into premium costs
  - Moves in the opposite direction of desired policy
  - Does not expand tax base
  - Exceed Cadillac Tax threshold faster and increase potential liability
- Other Provider Taxes
  - Likely increases premiums since it will be baked into provider prices
  - Moves in the opposite direction of desired policy
  - Lack of transparency
  - Subject of current litigation
  - Exceed Cadillac Tax threshold faster and increase potential liability

Contact:

Lawrence Miller

Chief of Health Care Reform

lawrence.miller@state.vt.us

802-989-0569