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STATE OF VERMONT
LEGISLATIVE JOINT FISCAL OFFICE

Independent Review of the Agency of Administration's Final Estimate of the Costs of Providing Primary Care to All Vermont Residents

January 6, 2016

As required by Act 54, Sec. 18

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JFO Independent Review of the Agency of Administration's Final Estimate

of the Costs of Providing Primary Care to All Vermont Residents

Sec. 18 of Act 54 required the Agency of Administration or its designee to provide an estimate of the costs of providing primary care to all Vermont residents, with and without cost sharing by the patient, beginning on January 1, 2017. Sec. 18 further required the Joint Fiscal Office (JFO) to conduct an independent review of the draft estimate and provide its final analysis of the cost estimates to the Legislature on or before January 6, 2016.

This report conveys comments and analysis of the Joint Fiscal Office in response to the Final Report of December 16, 2015, and explains the basis for those comments and analysis.

Overview of the Process Leading up to the Cost Estimates

JFO appreciates the effort and care that went into the process leading up to the Final Report. The approach taken was a cooperative endeavor among the Agency of Administration (AoA), the Wakely Consulting Group, and JFO. The AoA also reached out to other interested parties. The contract funded by the Legislature offered limited time and resources to analyze a potentially complex new system of universal primary care, and the work was carried out in a professional manner. Reports and analyses were delivered on time and represent big steps forward in terms of understanding what a new system of universal primary care would entail.

JFO submitted its preliminary comments and feedback on the draft report to the Agency on Administration on December 2, 2015. Those comments are attached to this report and also appear in Appendix E of the Final Report. The Final Report reflects a number of responses to JFO's initial suggestions. This review contains key issues that merit attention.

Summary of Estimates and Issues in the Final Report

The Final Report estimates the amount to be publicly financed under a system of universal primary care that included cost sharing would range from $121 million to $138 million to cover the cost of medical claims and administrative expenses. If provider reimbursement rates were increased between 10 percent and 50 percent with proportionate cost sharing, the additional total costs would be $22 million to $110 million, including the increased costs for Medicaid.

With no member cost sharing, the estimated amount to be publicly financed would range from $187 to $209 million for claims and administrative expenses. Increasing reimbursement rates for providers between 10 percent and 50 percent would require another $27 million to $135 million, including the costs for Medicaid.

The focus of the Final Report was mostly on medical claims, but additional issues and concerns will be important as the debate around universal primary care moves forward in the Legislature. As the report

makes clear in the Summary on page 8 and in the body of the report on pages 27 to 31, additional analysis and details are necessary to evaluate fully the costs and benefits of a new system of providing primary care to all Vermonters. This review will enumerate some of the areas where additional analysis will be essential.

Areas of Concern

Based on the estimates provided in the Report of December 16, 2015, there are six major areas of concern:

1. The report needs more clarity regarding additional amounts to be publicly financed and potential savings to the private sector

According to the Report, the amount to be publicly financed based on medical claims alone would be between $113 million and $175 million after netting out Medicaid expenditures. Other items need to be considered as well. For example, public employers in Vermont already pay for primary care through health insurance costs for State employees, municipal employees, and school employees. Those expenses should be netted out from the estimate of the new amount to be publicly financed. Other costs associated with the new system of universal primary care that should be added to the amount to be publicly financed are discussed in points 3 and 4 below.

If the public sector provided primary care to everyone in Vermont, we would expect to see private insurance costs and uncompensated care expenses drop. Those offsets would help to justify a large, new expenditure by the State that must be financed through new revenues. The current report does not touch the issue of how much private insurance premiums might fall. Nor does it contain an estimate of cost savings to the public sector as uncompensated care associated with primary care dwindles or the loss of revenues that would occur if primary care were to be exempt from Vermont's claims assessment.[1] As a result, questions remain about the true net cost of implementing universal primary care.

2. Additional administrative costs would arise from a new system of primary care

Introducing a new payment system for some portion of health care services seems likely to add complexity to an already complicated health insurance system. JFO has little basis on which to judge the range of administrative expenses adopted in the report for a new system of universal primary care. The range for administrative costs depicted in the report is 7 percent to 15 percent of primary care claims. That range generally covers administrative costs for overall health care, but administrative costs specific to primary care could differ if insurance coverage were more straightforward than in more complex health care. On the other hand, introducing a new system of insurance for primary care would likely add new time demands and new administrative costs for primary care providers and perhaps for insurers as well. We might expect to see additional administrative costs stemming from the need to sort out which payer reimburses costs for different types of care. Additional work would provide further insight.

[1] Vermont's claims assessment is 0.8 percent on the value of the medical claim. If the State of Vermont provided universal primary care, it would not make sense to levy the assessment on State-provided primary care.

The December 16, 2015 version of the Final Report also shows administrative costs of 7 percent to 15 percent of claims under the status quo. Those estimates do not reflect actual administrative costs for primary care claims under the status quo because they are unknown. JFO finds the current presentation confusing.

3. As was the case with the State's efforts on single-payer health care and recent experience with Vermont Health Connect, transition costs and issues will be critical

Starting up a new system of universal primary care on January 1, 2017, as stated in the legislation, is unrealistic. Introducing a new health care system such as universal primary care could cause unanticipated transition problems and expenses. A number of issues must be resolved:

- Reserves. In the private sector, reserves between 10 percent and 15 percent of costs are considered prudent for health insurers.[2] If the State acts as the ultimate insurer of the new primary care system, those reserves should be in place during the first year of operation. Such reserves would require additional funding of $12 million to $35 million. If the State were not the ultimate insurer but needed to obtain reinsurance, those costs should be made explicit as well.
- Information technology (IT). Vermont's experience with analyzing single-payer health insurance and implementing its health insurance exchange, Vermont Health Connect, has been rocky and much more expensive than anticipated. A new, coordinated information technology (IT) system that interfaces with existing IT systems could be required for a system of universal primary care, and it needs to be in place when the new system goes live. Costs could be substantial, the time needed to build the system could be extensive, and the extent of federal reimbursement is unknown.
- Training and education for providers. Significant training for providers might be necessary to differentiate primary care costs covered by the new system from costs that would remain under the current health insurance system. Such training would require both time and money.
- Changes for patients. Patients would experience disruption during the transition as well. Some patients would move from health insurance plans with higher actuarial value to the proposed State-provided plan with 87 percent actuarial value, and their deductibles and co-payments might rise unexpectedly. In the case of no cost sharing or for patients with lower actuarial value plans, all primary care would be provided at less cost to patients, perhaps inducing additional demand for care that would impact needed resources. Collective bargaining agreements would have to be renegotiated, recognizing that some of those contracts are in place for 2 or 3 years.
- Changes for employers. Employers would face transition issues as well. Employers in states that border Vermont would have to decide whether to adjust their employer-sponsored insurance plans to accommodate Vermont residents who would no longer need primary care insurance. Vermont employers might decide to change their employer-sponsored employer plans to

[2] BlueCross BlueShield of Vermont currently has about 10 percent to 12 percent of annual claims in surplus (personal conversation). For comparison, a Center for Budget and Policy Priorities report (2014) suggests that states should hold budget reserves of 10 percent of expenditures or more. http://www.cbpp.org//sites/default/files/atoms/files/4-16-14sfp.pdf

reflect State provision of primary care, thereby removing primary care insurance from employees who live outside Vermont. Alternatively, those Vermont employers might need to offer additional plans to serve both in-state and out-of-state employees.

- Changes for the health insurance industry. The health insurance industry would need to revamp its insurance plans and set premiums for new plans without primary care.
- Changes in the structure of public-private financing. The State would need to collect sizable amounts of new revenues prior to implementation to cover start-up costs and reimburse providers in a timely manner. In general, achieving increases in revenues takes time, particularly if income-based tax revenues are involved. The State collects income-based taxes on a calendar-year basis, suggesting that legislation for a new tax package should be passed one or two years prior to implementing a universal primary care system. Moreover, analysis of the impact of raising those new funds on the people of Vermont and on the State's economy would be highly desirable.

4. The base case should reflect the updated Medicaid population number

As flagged in our December 2, 2015 report on the draft cost estimates, the Medicaid population in the base case is too low given recent Medicaid experience. The base case uses Medicaid enrollment of 150,500 in 2017; the recent consensus estimate for 2017 is about 171,400. JFO would like to see the updated Medicaid numbers used in the Final Report's base case throughout the report to reflect expected costs in 2017.

Vermont is already struggling to pay the costs of providing Medicaid to its current enrollees. Additional growth in Medicaid spending will put further strain on public funding. The Report assumes that the State will pay its share of additional Medicaid costs as costs and enrollments continue to grow.

If Medicaid continues to grow as currently projected and the State finds a way to fund the additional spending, the new net cost of providing universal primary care could be lower than the estimates in the Final Report. As shown in Appendix B of the Final Report's Appendix B (p. 98 of the pdf online), using the higher Medicaid enrollment number leads to higher total costs for universal primary care but lower net additional costs to be paid for primary care by the State.[3] Total costs for universal primary care rise from $282 million to $290 million using the consensus number of Medicaid enrollees at the higher rate per member per month. Vermont and the federal government are expected to cover those costs under the status quo. Netting out the Medicaid costs leads to a lower net cost to be publicly financed. The net cost estimate based on the higher Medicaid enrollment is about $6.5 million lower than the base case.

5. Future health cost trends could mean substantially higher costs in future years

Table 2 in Appendix B of the Final Report's Appendix B (page 95 of the pdf online) shows how uncertainty in health care cost trends could affect the estimated cost of universal primary care in 2017. In the base case, payment rates would rise 3.0 percent annually in the commercial market, 1.7 percent in Medicaid, and 0.2 percent in Medicare. JFO believes those cost trends are low given recent

[3] It would help the reader if the structure of the Appendices in the Final Report were better organized.

experience and projections. The country appears to be returning to the traditional situation in which health care costs grow faster than revenues. For example, the Centers for Medicare & Medicaid Services (CMS) projected in July 2015 that overall health care spending would grow 5.3 percent in 2015 and that overall growth would continue to rise until reaching 6.3 percent in 2020.[4] CMS expects health care spending in the private sector to rise 5.4 percent on average between 2016 and 2024, Medicare 7.3 percent per year, and Medicaid 5.9 percent per year. Even after removing as much as 0.9 percent per year for population growth that might not occur in Vermont and making adjustments for the different demographics of the primary care population in Vermont that would omit most people age 65 or older, the current projections are several percentage points higher than those used in the Final Report.[5] Higher cost trends would further exacerbate the State's current fiscal problem as spending grows faster than revenues, and only a multi-year analysis would accurately portray that divergence between costs and revenues.

Wakely's analysis shows that every 1 percentage point increase in the growth of health care costs above the assumed trend would lead to an increase of about $8.6 million in the gross cost. Faster growth by 3 percentage points, for example, would increase costs by about $25 million in 2017. Rate trends that are lower by 1 percentage point would lead to lower gross costs of about $8.4 million. Those differences would compound in future years, leading to significant uncertainty regarding the cost of a universal primary care program in future years.

6. More thought is needed concerning integration with the health care reform initiatives such as the all-payer model

How universal primary care would interact with health care reform initiatives such as the all-payer model, changes in statewide provider reimbursement rates, or expansion of accountable care organizations (ACOs) needs additional thought. The all-payer model is still under negotiation with CMS. Offering universal primary care needs to be understood in the context of other health care initiatives and how it would affect costs, access, and the quality of health care. For example, ACOs receive a payment based on the number of people under their care. It seems quite possible that the primary care payments set by the State might not align with the ACO allotments for primary care.

Concluding Remarks

Overall, JFO appreciates the work of the Agency of Administration on universal primary care, particularly in light of the limited budget to fund the outside contract. The Final Report provides useful information that will inform the debate. For the reasons laid out above, however, JFO would urge further work and study before moving forward.

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[4] Centers for Medicare & Medicaid Services, National Health Expenditure Projections 2014-2024, July 2015. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2014.pdf

[5] In the December 2015 "Public Employees' Health Benefits Report" from Vermont's Agency of Administration, the annual growth rate for health care costs for public employers was 6.5 percent in the base case.