ONE BALDWIN STREET
MONTPELIER, VT 05633-5701

PHONE: (802) 828-2295
FAX: (802) 828-2483
WEBSITE: www.leg.state.vt.us/jfo/

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

Prepared by
Joyce Manchester
Legislative Joint Fiscal Office

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.

[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.

ONE BALDWIN STREET
MONTPELIER, VT 05633-5701

PHONE: (802) 828-2295
FAX: (802) 828-2483
WEBSITE: www.leg.state.vt.us/jfo/

STATE OF VERMONT
LEGISLATIVE JOINT FISCAL OFFICE

Attachment

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

December 2, 2015

As required by Act 54, Section 18

Prepared by
Joyce Manchester
and Nolan Langweil
Legislative Joint Fiscal Office

JFO Independent Review of the AoA Draft Estimate of the Costs of Providing Primary Care to All Vermont Residents

Section 18 of Act 54 required the Agency of Administration or its designee to provide "a draft 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." Section 18 further required the Joint Fiscal Office (JFO) to conduct an independent review of the draft estimate and provide its comments and feedback to the Secretary or designee on or before December 2, 2015.

This report conveys the primary comments and feedback of the Joint Fiscal Office in response to the draft report of October 15, 2015, and explains the basis for those comments and feedback.

General Remarks about the Cost Estimates

JFO is aware that much effort went into defining exactly what the phrase "primary care" means and turning that definition into billing codes used by the various providers. JFO applauds that effort and agrees with the definition of services and providers as presented in the draft report.

JFO appreciates the efforts by Wakely Consulting Group to generate estimates of the cost of medical claims under a system of universal primary care in Vermont starting January 1, 2017. In addition, we thank Wakely for responding to many of our concerns during the October-November comment period. We look forward to updated estimates with additional scenarios in the next version of the report.

Overview

Based on the draft estimate provided to JFO on October 15, 2015, three major concerns arise:

- <u>The report provides cost estimates stemming from medical claims only.</u> "Costs of providing primary care to all Vermont residents" include more than the costs of medical claims alone. JFO would like to see a discussion—and numbers where possible—to cover the costs of transition and start-up, reserves, administration and oversight, information technology, potential impacts on state revenues, and the loss of federal subsidies for health care in Vermont. Other issues related to a move to universal primary care arise as well. JFO would like to see a discussion of the ability of primary care providers to meet the need if demand grows significantly. Some people are already concerned about sufficient access to primary care under the status quo, and additional demand could exacerbate any existing problem areas. A related issue is whether higher reimbursement rates would be necessary to ensure access to providers. The report addresses that issue generally but a more thorough discussion would be useful. Recognizing that the legislation set a benchmark date of January 1, 2017, the infeasibility of implementing

universal primary care in Vermont by 2017 without incurring sizeable additional costs is also a concern.

If "other non-medical costs" are not included in the report's cost estimates, the executive summary should prominently highlight that omission with statements such as the following: "The analysis here is for claims costs only. Total costs will be higher when other factors such as administrative and start-up costs are included. In addition, the report should include a discussion of implementation challenges if universal primary care begins in 2017."

- The cost estimates rely on outdated numbers to allocate Vermonters among different insurance types. In particular, the distribution of types of insurance used by Vermonters in the report may understate Medicaid enrollment. The report's estimate of Medicaid enrollment in 2017 relies on Medicaid enrollments in 2014, but higher-than-anticipated enrollments in 2015 surprised Vermont policy makers. JFO sent updated projections for a couple of the various insurance types to Wakely in November. It also appears that Wakely used state fiscal year enrollments (July 1st to June 30) to obtain spending over calendar years. Because Medicaid enrollments have been growing over time, using calendar year enrollments could lead to somewhat higher estimates of Medicaid enrollments. Costs to the State would be slightly lower, however, because the federal government pays for part of Medicaid expenses.

- The report does not analyze uncertainty surrounding the rate at which primary care costs might grow. Costs in 2017 depend strongly on the trend rate of health care costs between the base year and 2017. JFO would like to see sensitivity analysis or at least a discussion to recognize the effect of faster or slower growth in health care costs between the base year and 2017. The base year for Medicare data is 2012; the base year for data for Medicaid and commercial health insurance is 2014.

  In addition, the report currently says nothing about costs of providing universal primary care beyond 2017. Some discussion of expected cost growth rates beyond 2017 will be important for policy makers as they contemplate future costs.

Other issues appear below, including how much additional demand for primary health care might come from having free or almost free primary care, how universal primary care would interact with other State initiatives such as an all-payer model and accountable care organizations (ACOs), the need to clarify net new costs to the State of Vermont, and possible cost savings derived from more appropriate use of different types of health care facilities and improved population health over time.

JFO Concerns with the Draft Estimates

1. The report provides cost estimates stemming from medical claims only.

JFO recognizes that the majority of on-going costs of providing universal primary care to Vermonters will come from the claims for primary care. However, policy makers need complete information about the total costs of the initiative before they can make an informed decision about its possible implementation. The following items should be included in the cost estimate; if estimating the cost of the items is not possible at this time, the report should include discussion of each item:

- Reserves and/or reinsurance
- Start-up costs and transition costs, both one-time and on-going, such as information technology (IT) for both the payers and the providers
- Administrative complications and/or new responsibilities, including coordination of benefits, multiple billing for single visits, oversight, quality assurance, and the like
- The possibility of higher reimbursement rates for providers as a possible strategy to meet demand
- Implications for existing state revenue sources (e.g., the health care claims tax)
- Growth in primary care costs in future years that could increase state funds needed
- Loss of federal tax expenditure for HSAs and also employer-sponsored insurance
- Changes in who pays for primary care among state, federal, and other providers

For example, it would be prudent for the State of Vermont to hold reserves greater than 10 percent of the expected expenditure incurred for primary care in the first years of implementation to protect the state from extraordinary costs. Alternatively, the report could acknowledge the price at which the state could buy reinsurance or discuss other ways to offload risk.

The report currently glosses over start-up costs such as establishing an IT system to communicate with payers and providers. The introduction of a new, widespread program such as universal primary care would undoubtedly present many complicated issues involving oversight, quality assurance, fraud prevention, and the like. Those issues need sufficient attention and resources prior to implementation. Given the recent experience with Vermont Health Connect, the report needs to address time needed, system issues, and costs in transitioning to the new system. Implications for existing state funding sources such as the health care claims tax require analysis as well.

Legislators also need to know what will happen to the costs of providing universal primary care beyond the first year of implementation. Health care costs historically have increased faster than general inflation or real economic growth, and most analysts expect that trend to continue. The report would be more useful if it contained a discussion of likely costs going forward.

The loss of federal tax subsidies as a consequence of adopting a universal primary health care program in Vermont is also a concern, but the current draft does not address it. Many Vermonters today obtain health insurance through their employer. They are able to pay health insurance premiums as well as contribute to Health Savings Accounts (HSAs) or Health Reimbursement Accounts (HRAs) using pre-tax dollars. Neither income taxes nor payroll taxes are levied on the total premium—both the share paid by the employer and the share paid by the employee. If their employer-provided health insurance no longer covers primary care services, they will lose the tax exclusion for the premium amount that today covers those primary care services. As a result, the people of Vermont could lose a sizeable federal subsidy to the State's economy.

A number of policy issues arise beyond the "costs" of providing primary care for all Vermonters. JFO would like to see a discussion of the ability of primary care providers to increase available services if universal primary care led to greater demand but no increase in the supply of primary care providers. Geographical differences in access to primary care could be an important issue, particularly in regions of Vermont that already may be understaffed for medical care or behavioral health services. A discussion of possibly higher reimbursement rates to boost the supply of primary care services would be helpful.

The infeasibility of implementing universal primary care in Vermont in 2017 is a concern as well, although we recognize that Act 54 established the timeframe. Even if the legislature passed a universal primary care law in the upcoming session, given all of the planning, analysis, infrastructure needs, and coordination that would need to take place, putting the system in place by January 1, 2017, seems next to impossible. Implementation issues that arose in the early days of the ACA illustrate the importance of not rushing the rollout of a major change in the health care system.

2. The report does not analyze uncertainty surrounding the rate at which primary care costs might grow.

The dollar figure estimated for 2017 depends on the trends in primary care cost growth assumed for years between the base year for each type of coverage and the implementation year of 2017. The base year for commercial insurance and Medicaid is 2014, and the base year for Medicare is 2012. As shown in Table 1, the Wakely estimates use one set of trends in utilization, or services used, and payment rates.

Table 1. Trends in Utilization and Payment Rates, Annual Rates of Growth

	Utilization Trend	Payment Rate Trend
Commercial	1.0%	3.0%
Medicaid	0.9%	1.7%
Medicare	0.9%	0.2%

In light of considerable uncertainty about the cost trends, JFO would like to see sensitivity analysis using growth rates in payment rates that are 1 percentage point above and 1 percentage point below the

trends shown above. If such sensitivity analysis is not possible, a discussion of the potential effect of different rates of growth on costs would be helpful.

3. The cost estimates rely on outdated numbers to allocate Vermonters among different insurance types.

The distribution of types of insurance used by Vermonters in the report is outdated and likely understates Medicaid enrollment in particular, which in turn may overstate commercial enrollment. Because the State of Vermont pays a substantial share of Medicaid costs incurred by Vermont residents, undercounting the number of Medicaid patients may lead to inaccurate estimates of the cost of providing universal primary care under the status quo and of net new costs to the State under universal primary care.

The report's current estimate of Medicaid enrollment in 2017 relies on actual Medicaid enrollments in State fiscal year (SFY) 2014, but higher-than-anticipated enrollments in SFY 2015 surprised Vermont policy makers. Actual enrollments in SFY 2015 suggest a higher Medicaid trend than projected in the report.

JFO acknowledges that some uncertainty accompanies the Vermont Medicaid projections for SFY 2016 and 2017. One possible reason is that Medicaid eligibility redeterminations have been on hold for a year as the State was sorting out problems with Vermont Health Connect. When those redeterminations resume in 2016, the numbers of people enrolled in Medicaid for their primary coverage could change. JFO sent updated projections where available to Wakely in November (see Table 2 below). Adjusting those numbers will affect status quo costs as well as projected costs under universal primary care.

In the October 2015 cost estimates, Wakely used state fiscal year enrollments (covering July 1st to June 30) to calculate spending over calendar years. Growing Medicaid enrollments over time imply that using calendar year enrollments would show slightly higher Medicaid enrollment in 2017. Higher Medicaid enrollment means lower primary care costs to the State because the federal government pays about half of Medicaid costs for enrollees.

In addition, the report uses federal match rates, known as FMAP and based on federal fiscal years, to calculate calendar year Medicaid cost estimates. JFO cannot discern whether the federal match rates were blended across federal fiscal years to correspond with the calendar years used in the report. Doing so is important to account for the state and federal shares of Medicaid costs properly. Adjusting both enrollments and the FMAP for calendar years could lead to higher or lower costs of providing universal primary care in the State of Vermont.

Table 2.	Wakely Estimate	Working JFO Estimate	JFO Comments
Market	2017	2017	
Commercial	300,200	See notes	One piece of the commercial market is the individual market. If the basis for the Wakely number for commercial insurance is last year's data, the individual market estimates may be too high. DVHA budget estimates for SFY'15 were that 42,785 people would receive Vermont Premium Assistance. Revised budget adjustment estimates lowered the number to 18,007. Actual SFY'15 VPA enrollment was 13,177. It is likely that the estimate overstates the individual market in the commercial estimates.
Military	14,500	See notes	This estimate may be too low. According to the 2014 VT Household Insurance Survey (VHHIS), military insurance covers 18,547 lives. Why might it drop by 4,000 by 2017?
Federal	14,600	No JFO estimate	
Medicaid – primary only	150,500	See notes	SFY'15 actual enrollment for Medicaid as a primary source of coverage was 156,228. The current JFO/Admin consensus estimates, although not yet finalized, are 165,642 for SFY'16 BAA and 171,428 for SFY'17. Furthermore, if they were converted to calendar year, they would be slightly higher. Those numbers are not yet finalized, and we are not sure what effect Medicaid redeterminations will have on enrollments. Nonetheless, we firmly believe an estimate of 150,500 is too low.
Medicare	142,500	131,600	Using the same ratio of Medicare enrollees to the 0-64 and 65+ populations as in 2012, we estimate 137,100 primary Medicare enrollees in 2017. However, a greater share of 65+ people in 2017 will continue to work and have ESI as primary coverage. Using 95% of the 65+ number gives us 131,600 in 2017.
Uninsured	13,300	See notes	The Wakely estimate appears to be too low. An uninsured rate of 2.1% seems unlikely and would be unprecedented. The VHHIS uninsured rate for 2014 was 3.7%. In the absence of significant policy intervention, we have no reason to believe that the uninsured rate will drop much more. An uninsured rate of 3.7% yields 23,300; if the rate is 3.3%, the number is 21,000.
Total	635,600	629,600	Official Consensus Joint Fiscal Office-Administration projection developed by Kavet and Carr in October 2015. The precise number projected for 2017 is 629,574.

Finally, JFO is concerned that Wakely is using a projection of Vermont's population in 2017 that is too large. Based on the Census estimate for 2011 through 2014, the October 2015 Kavet-Carr consensus projection for Vermont in 2017 appears in Table 2. Population growth was very slow between 2010 and 2014, and the Kavet-Carr projections raise that rate of growth somewhat to reflect a stronger economy. Reaching 629,600 in 2017 seems plausible, but the report's estimate of 635,600 seems too high.

4. Additional concerns

a. Additional demand for primary care given the availability of free or almost free care

The draft cost estimates use one set of assumptions regarding induced demand, or how much additional care Vermonters will demand given State provision of primary care to most of the population. Uncertainty surrounds estimates of demand for health care at low or zero cost sharing; sensitivity analysis would show how different assumptions for induced demand affect the cost estimates.

JFO would like to see a more in-depth treatment of induced demand in two areas. First, significant uncertainty surrounds the estimates of demand for primary care when no cost sharing occurs because not much evidence exists on consumer behavior when patients bear none of the costs. For example, differences could arise in induced demand for care among people of different ages, or among people with chronic conditions.

Wakely currently uses induced demand factors from the U.S. Department for Health and Human Services for insurance plans with actuarial values from 60 percent to 90 percent; Wakely interpolated factors at other levels of actuarial value (see Table 3).[6] JFO would like to see sensitivity analysis using larger factors in particular for plans at the 100 percent actuarial value. Little recent evidence exists to indicate how much demand for primary care might change if people face no costs of obtaining health care.[7] The "no cost sharing" cost estimate currently in the draft report might change under different induced demand factors; knowing how sensitive costs might be to that particular factor is important.

Second, the estimates assume that little induced demand would come from people who relocate to Vermont to access state-provided primary care. JFO would like to see additional discussion of the assumption in this area prior to a more in-depth study of the issue that might come following the Final Report.

[6] Actuarial value is the average percentage of health care costs a health plan will cover under a particular plan. One minus the AV is the average percentage of health care costs incurred by the patient in a particular plan.
[7] The RAND Health Insurance Experiment, conducted in the United States between 1974 and 1982, remains the only long-term, experimental study of cost sharing and its effect on service use, quality of care, and health. Participants who paid for a share of their health care used fewer health services than a comparison group given free care. In addition, free care led to improvements in hypertension, vision, and selected serious symptoms, especially among the sickest and poorest patients. http://www.rand.org/pubs/research_briefs/RB9174.html

Table 3. Induced Demand Factors for Plans with Different Actuarial Values

Actuarial Value, or Percent Paid by Plan	Induced Demand Factor Now Assumed
100	1.24
90*	1.15
80*	1.08
70*	1.03
60*	1.00
50	0.975
40	0.955
30	0.938
20	0.925

*Note: Factors in blue came from the U.S. Department of Health and Human Services. Other factors were interpolated by Wakely.

b. Implications of universal primary care for payment reform initiatives

Vermont has several large-scale payment reform initiatives underway. The State is negotiating with the Center for Medicare and Medicaid Services (CMS) regarding an all-payer model, and substantial resources have already been invested in accountable care organizations (ACOs). It would be most helpful to see a paragraph or two in the report explaining how universal primary care would interact or impact those initiatives.

c. More detail needed on net new costs to the state

The report does not differentiate clearly between costs already incurred by the State and net new costs. JFO would like to see additional detail regarding the amounts to be publicly financed by the State of Vermont. It would be helpful to add a column showing "Amounts to be Publicly Financed" to Tables 2-5 and 6 in the draft report. For example, the State already pays a share of Medicaid costs and pays for State employees (both active and retired), retired teachers, and Medicare buy-in enrollees. The draft does not explain clearly whether "net cost" recognizes those costs.

d. Possible cost savings depending on how the system is set up operationally

Having a system of universal primary care could result in cost savings in some areas if it works as many people expect. For example, we might expect reduced use of emergency room care for ailments such as sore throats or sprained ankles, and uncompensated care should drop significantly if all residents have primary care available to them. Over the longer term, we might expect improvement in general health status because everyone will have received basic care over their lifetimes.

On the other hand, incentives might exist that would raise the cost of care overall. For example, primary care providers might be encouraged to send patients to specialists for what could be considered routine care if the reimbursement rates of specialists are higher. Similarly, the practice of assigning an

inaccurate billing code to a medical procedure or treatment to increase reimbursement—known as upcoding—could occur more frequently without proper oversight or regulation.

e. Presentation issues

Various aspects of the report might be difficult for non-technical people to digest. For example, the report analyzes alternative scenarios with Medicaid reimbursement rates increased by 10 percent, 20 percent, and 50 percent. Legislators are familiar with comparing Medicaid reimbursement rates to Medicare reimbursement rates. It might be helpful to relate the various levels of increased Medicaid reimbursement rates to Medicare reimbursement rates to the extent possible. JFO believes such a comparison is doable without "endorsing" particular levels of reimbursement.