Act 128 Report Overview
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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 <u>three options</u>

1) Government-run Single Payer system
2) Public Option
3) Public-Private Single Payer *(Dr. Hsiao's recommended option)*
   - 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 – <u>funds needed would have to come from savings</u>
- 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 <u>Medicare</u> 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%

Caveats & considerations concerning estimated savings:

- *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 and/or be realized 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).*
- *Report recognized that "these savings are inherently uncertain and the true impact would depend largely on how the proposed system in implemented."*

Identified <u>sources of savings</u> under proposals

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.

<u>Use of savings</u> 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

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

Dr. Hsiao Recommended Option 3.

	2016		2019	
Benefits package	**Standard (Options 1B and 3)**	**Comprehensive (Option 1 A)**	**Standard (Options 1B and 3)**	**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 tax contribution (by both employers and employees)
  - Exempted employer and employee share for low wage workers.
    - But recommends this exemption be phased out.
  - Recommended Vermont residents who work out-of-state for employers who do not offer health coverage, should pay the employers payroll tax contribution.
  - Estimated no additional cost to most employers and workers.
  - Payroll was capped at $106,800 – same cap as social security payroll contribution that is indexed to GDP.
- Federal grant equal to the amount of exchange subsidies and small business tax credits the state would have received under the ACA.
- Assumes enhanced Medicaid match for New Adult Medicaid population under the ACA

- Assumes federal match for increases in Medicaid reimbursement rates laid out in plan.
- Assumes estimated savings would be reinvested (above)

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.

Payroll tax based on the following basic principles:

- Equity – financing should take into consideration ability to pay
- Risk Pooling – pooling healthy and less healthy people into one risk pool so that large unpredictable individual risks are distributed across all members of the pool.
- Minimize adverse economic effects – Financing should be designed to minimize potential adverse effects on the overall economy, labor market, and household incomes.
- Work within federal tax laws – financing should be designed to maintain favorable tax treatments/exemptions for Vermont employers and workers – estimated at the time to be about $500 million for Vermont
- Incentivize health promotion and health lifestyle choices
- Maximize federal funds

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

The Full Act 128 - Hsiao Report and other related documents can be found on the Joint Fiscal Office website:
http://www.leg.state.vt.us/jfo/healthcaresystemdesign.aspx