State of Vermont
Agency of Human Services
Office of the Secretary
280 State Drive [phone] 802-241-0440
Waterbury, VT 05671-1000 [fax] 802-241-0450
humanservices.vermont.gov

Date: April 19, 2022

To: Senator Lyons, Chair, Senate Committee on Health and Welfare

From: Adaline Strumolo, Deputy Commissioner, Department of Vermont Health Access

Sean Sheehan, Special Projects Director, Agency of Human Services

Re: H. 287 An act relating to patient financial assistance policies and medical debt protection

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Overview

Ensuring Vermonters have access to affordable health care is a central part of the work of the Agency of Human Services and the Department of Vermont Health Access. We recognize this as the overarching goal of H. 287 and would like to take this opportunity to provide feedback on the bill's proposed mechanism to achieve that goal. We support transparency and equity across the system of the hospital financial assistance; however, we believe more analysis is needed related to addressing medical debt and maximizing federal funds through changes to the system. We encourage the Committee to consider broader implications, such as the bill's potential impacts on Vermont's uninsured rate, cost of health insurance, and use of primary care. This memo closes with recommendations for the path forward.

Consistency and transparency in hospital financial assistance

AHS and DVHA support the goal of creating consistency, clarity and equity across the system of hospital financial assistance. As H. 287's proponents note, Vermont's current patchwork of financial assistance programs are not well known or understood. Vermonters in similar financial situations encounter substantially different access to free care based on where they live and how well they know the system. As the 2021 Vermont Household Health Insurance Survey illustrates, health equity is a crucial challenge in Vermont. H. 287 requires hospitals to robustly promote the new, standardized program – a good thing for health equity.

Medical debt and maximizing federal dollars

AHS and DVHA also support the goals of addressing medical debt and maximizing federal dollars; however, we believe more analysis is needed on whether H. 287 as drafted is the right tool to address them.

1. Medical debt - The proposal aims to address the problem of Vermont families having a hard time paying medical bills. However, the data show this to be a problem that has been steadily improving, not worsening, over the last decade. Fourteen percent of Vermont households had problems paying medical bills in 2021, down from 22% in 2014 (see Figure 1). Vermont should continue to strive for continued

improvement on this metric of course, but it may be helpful to further explore what's working and what's not before prescribing statewide financial assistance structures. Of note, the 2021 Household Health Insurance Survey points out both that insured Vermonters are less likely than uninsured Vermonters to have problems paying medical bills and that the improvement in the proportion of Vermonters who have problems paying bills has occurred alongside an increase in the proportion of Vermonters who have health insurance.

2. Insufficient use of federal dollars – Proponents note that Vermont fails to utilize its maximum allotment of Disproportionate Share Hospital (DSH) Payments and is thus leaving federal dollars on the table (while not appropriating the state match, of course). A more complex analysis would be needed to determine whether an increased use of DSH would in fact increase Vermont's overall drawdown of federal dollars. If DSH payments displace federal tax credits for health insurance marketplace members, for example, Vermont could face a decreased drawdown of federal dollars because those tax credits are 100% federal and do not require a state match. In the state's health insurance marketplace, individuals at the income levels impacted by H. 287 receive more than $100M in federal tax credits each year. It would be important to consider the effect of some portion of these people dropping their coverage and federal subsidies as compared to the benefit of DSH and its Vermont match.

Unintended consequences

In creating too generous a hospital financial assistance framework the bill could disincentivize Vermonters from purchasing health insurance. This creates adverse selection, with younger and healthier Vermonters not entering the health insurance market and putting upward pressure on health insurance rates. It could also discourage use of primary care and mental health care that comes with traditional insurance.

1. The insured rate – Vermont has the second highest insured rate in the nation. However, H. 287 proposes to give a hospital-funded discount on health care costs to a majority of Vermonters (those up to 400% of the federal poverty level, or FPL), and completely free care to a significant portion (those up to 250% FPL), with no difference in benefit regardless of whether they buy health insurance. It also proposes to give effectively free catastrophic coverage to a large majority of Vermonters (those up to 600% FPL), again with the same cap on out-of-pocket costs regardless of whether they are paying for other health insurance.

   This proposed structure could promote adverse selection - driving healthier Vermonters out of the paid-insurance pool. If they stay healthy, they would save money by not paying a premium. If they have an accident or unexpected diagnosis, their total costs would still often be lower under the H. 287 structure than if they had purchased insurance. Adverse selection serves to increase insurance costs for everyone who remains in the pool.

   It is clear that existing financial assistance programs have had some impact in discouraging Vermonters from buying health insurance. It is logical to expect that clear statewide standardization of incentive structures, the addition of the "universal catastrophic" component, and improved communication should increase the number of Vermonters who opt to be uninsured. However, the extent of the expected impact is one that merits more analysis.

   In fall 2021, DVHA asked Vermont Health Connect Assisters if they encountered clients who opted not to sign up for marketplace insurance even in the face of expanded American Rescue Plan subsidies and,

if so, what were the reasons. Assisters said hospital financial assistance programs were one of the primary reasons cited by clients who chose not to enroll.

The Assisters' experience seems to be more representative of their experience with clients than of Vermont's uninsured population as a whole. After all, the 2021 Vermont Household Health Insurance Survey estimated that hospital free care was the main reason only about 1,000 Vermonters chose to go uninsured (i.e. the main reason for 6% of the state's 19,400 uninsured residents). One hypothesis might be that Assisters are more likely to encounter clients who know the health system well, while a larger segment of Vermonters – likely generally healthy, both insured and uninsured – are less likely to know free care exists. It is worth contemplating the potential impact of increased promotion alongside a more generous structure.

Examples are included as an appendix to this memo.

2. Efficient use of Vermont's health care resources and wait times - In paying for care in emergency rooms, the bill could incentivize the use of this critical resource instead of primary care and urgent care. Also, in offering effectively free catastrophic coverage, the proposed structure could entice Vermonters to neglect regular primary and mental health care that comes with traditional insurance.

Path Forward

AHS and DVHA appreciate the Committee's consideration of these points, including the unintended consequences of well-intended legislation. We are not able to offer a concrete alternative without further analysis. Therefore, we would recommend:

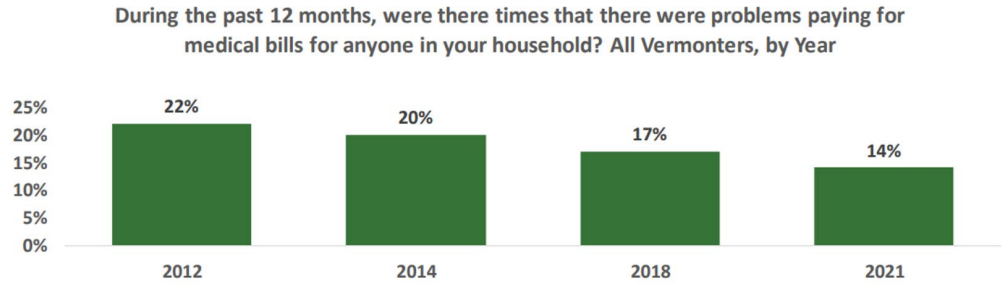
1. Amending the bill to mandate that hospitals prepare for all of the measures related to consistency of eligibility determinations and publicity of financial assistance programs by 2024, while postponing the decision surrounding the precise incentive structure until the 2023 legislative session.

2. During the coming year, analyze modifications to the proposed incentive structure to address unintended consequences. For example, the structure could be modified to ensure that being insured continues to be the better financial option for Vermonters. Provide a significantly larger benefit (i.e. more out-of-pocket protection) to people who are buying health insurance (including those who have Medicare) than to those who aren't. Consider allowing people who applied for subsidies in Vermont's health insurance marketplace and were rejected to get the insured member benefit from the hospitals (perhaps requiring a limited payment to account for the fact they don't have to pay a premium). Ensure consistency by articulating that a new statewide structure should be the standard, not just a floor (i.e. a ceiling as well as a floor).

Figure 1 - Data from 2021 Vermont Household Health Insurance Survey

Problems Paying Medical Bills

Vermonters were significantly less likely to have problems paying medical bills in 2021 than in 2012, 2014, or 2018.



	Estimated Population by Year
Response	All Vermonters (Insured and Uninsured)
2012	140,050
2014	124,023
2018	107,009
2021	85,141

Examples of Decision-Making Under H. 287

High-level discussions of the interplay between financial assistance structures and the decision to enroll in health insurance can be abstract. Looking at examples of people's specific options can help make the situation more tangible. Please note that 2022 figures are used for insurance costs, meaning that the option to go uninsured under H.287 can be expected to compare even more favorably in 2024.

Figure 2 - Examining the disincentive to buy health insurance and who pays

1) A couple earning $40,000 (under 250% FPL) qualify for nearly $17,000 per year in premium tax credits (100% federal dollars) as well as up to $600 in Vermont Premium Assistance (state/federal mix, split at Global Commitment rate). With this financial help, they can get a zero-premium health insurance plan. If they'd prefer a gold plan, they can buy one for less than a tenth of the sticker price. Or they can go uninsured, knowing that under H.287 they can get 100% free care paid by any hospital in the state (see Figure 2).

Scenario: Couple earning $40,000; each need a $25,000 treatment *This couple qualifies for subsidized health insurance. Under H.287 they also qualify for free care.*								
Health Insurance Status	Gross Annual Premium (Monthly)	Members' Net Annual Premium (Monthly)	Annual APTC - *100% federal*	Annual VPA- *>50% federal*	Max Out-of-Pocket	Hospital (under H287, presumably DSH)	Insurance Company	Total Annual Cost to Couple
MVP Plus Gold 3 HDHP	$18,486 ($1541/mo)	$1182 (<$99/mo)	$16,704	$600	$6,400	$6,400	<$43,600*	$1182
Blue Cross Bronze Plan	$13,754 ($1146/mo)	$0 ($0/mo)	$13,754	$0	$17,400	$17,400	<$32,600*	$0
Uninsured	N/A	N/A	N/A	N/A	N/A	$50,000	N/A	$0

*Insurance companies generally have negotiated rates with hospitals so would pay less than this amount.

Figure 3- A second example of the disincentive to buy health insurance and who pays

2) A couple in their late 20s earning $100,000 per year can buy a catastrophic couple plan from Blue Cross Blue Shield of Vermont or MVP Health Care, for $468 per month or $722 per month respectively. These plans have a $17,400 deductible and $17,400 max-out-of-pocket. Or they can go uninsured, knowing that even with a worst-case scenario they'd save money using the "free" catastrophic coverage from the hospitals (see Figure 3).

Scenario: 29-year-old couple earning $100,000; each need a $25,000 treatment *This couple does not qualify for subsidized health insurance. Under H.287 they qualify for free care above 20% of income.*								
Health Insurance Status	Gross Annual Premium (Monthly)	Members' Net Annual Premium (Monthly)	Annual APTC - *100% federal*	Annual VPA- *>50% federal*	Max Out-of-Pocket	Hospital (under H287, presumably DSH)	Insurance Company	Total Annual Cost to Couple
MVP Secure	$8,660 ($722/mo)	$8,660 ($722/mo)	$0	$0	$17,400	$17,400	<$32,600*	$26,060
Blue Cross Catastrophic	$5,620 ($468/mo)	$5,620 ($468/mo)	$0	$0	$17,400	$17,400	<$32,600*	$23,020
Uninsured	N/A	N/A	N/A	N/A	N/A	$50,000	N/A	$20,000

*Insurance companies generally have negotiated rates with hospitals so would pay less than this amount.