

THE CENTER FOR HEALTH POLICY, PLANNING
AND RESEARCH
UNIVERSITY OF NEW ENGLAND
716 STEVENS AVE.
PORTLAND, ME 04103
(207)221-4560
WWW.CHPPR.ORG

ACHIEVING UNIVERSAL COVERAGE
THROUGH COMPREHENSIVE
HEALTH REFORM:
THE VERMONT EXPERIENCE

REPORT OF FINDINGS



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Achieving Universal Coverage Through Comprehensive Health Reform: The Vermont Experience

The following staff and consultants at the UNE Center for Health Policy, Planning and Research (CHPPR) contributed to this evaluation:

Ronald Deprez, PhD, MPH⁺
Sherry Glied, PhD[^]
Steven Kappel, MPA^{*}
Mary Louie⁺
Bill Perry, MS⁺
Brian Robertson, PhD[~]
Kira Rodriguez, MHS⁺
Nina Schwabe⁺
Nicholas Tilipman[^]

⁺ Center for Health Policy, Planning and Research

[^] Columbia University Mailman School of Public Health

[~] Market Decisions, Inc.

^{*} Policy Integrity, LLC

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I. EXECUTIVE SUMMARY

This report presents the findings of a two-year comprehensive evaluation examining the impact of health care reform in Vermont initiated by the 2006 Health Care Affordability Acts (HCAA). The evaluation, conducted by the University of New England Center for Health Policy, Planning, and Research (CHPPR) with funding from the Robert Wood Johnson Foundation's (RWJF) State Health Access Reform Program, addresses three key dimensions of Vermont's comprehensive health reform, including:

- 1) Health coverage affordability,
- 2) Access to health coverage, and
- 3) Sustainability of the reforms.

Several key dimensions distinguish the HCAA from other state health insurance reform initiatives. HCAA is designed to expand insurance coverage within the context of comprehensive health system reform. It establishes a voluntary approach for individual enrollment and an assessment on employers if they do not offer health insurance to employees, or if their employees choose not to enroll in employer sponsored insurance (ESI) and are otherwise uninsured. The HCAA also uses a unique combination of income-generating and system-changing policies in attempt to achieve sustainability.

The report includes:

- Process evaluation findings from interviews with key stakeholders,
- An analysis of affordability and access using data from the 2005, 2008, and 2009 Vermont Household Health Information Surveys (VHHIS),
- Findings from enrollment data and data on employer sponsored insurance, and
- Analyses of sustainability using administrative data.

Health Reform in Vermont

The State of Vermont has had a long history with health care reform. Recent efforts include programs that expand Medicaid coverage beyond the traditional income limits. These include the Dr. Dynasaur program, a 1989 program to expand coverage to uninsured children, and the Vermont Health Access Program (VHAP), a 1995 program to expand coverage to low income, uninsured adults. Although these programs have provided coverage for many uninsured Vermonters, a survey conducted in 2005 indicated that approximately 10% of Vermont's population remained uninsured¹ while *per capita* health care costs were rising faster than the US rate.²

¹ 2005 Vermont Household Health Insurance Survey: Final, August 2006 Report; available at: http://www.bishca.state.vt.us/HcaDiv/Data_Reports/healthinsurmarket/2005_VHHIS_Final_080706.pdf

² National Health Expenditure Data, Health Expenditures by State, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, released February 2007; available at http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccountsResidence.asp#TopOfPage

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Acknowledging the existing financial demands on the health care system and the need for broader access, Vermont's policymakers agreed that the state could not provide better access to health insurance without extensive health care reform. In considering reform, they sought to achieve universal access to affordable health insurance for all Vermonters, to improve quality of care and contain costs through health care system reform, and to promote healthy behavior and disease prevention across the lifespan. These goals were interrelated: access to health insurance would increase the use of preventative services; lower health care costs would make insurance premiums more affordable; and promotion of healthy behavior and preventative services would help keep health care costs in check. Each component would play an essential role in ensuring successful reform.

In 2005, the democratically-controlled legislature enacted a comprehensive health care reform bill, but that bill was vetoed by Republican Governor Douglas. As Vermont's legislature convened in 2006, lawmakers knew that addressing these issues would take both creative thinking and political compromise. Despite conflicting perspectives between Governor Jim Douglas and the legislature on what health reform should look like, Vermont lawmakers were encouraged to reach a compromise on a state plan. In May 2006, the legislature passed and the Governor signed Acts 190 and 191, the Health Care Affordability Acts (HCAA) for Vermonters. Implementation of the HCAA began in early 2007. Modifications to the initial law have been ongoing since the initial passage to address implementation issues.

Evaluation Design and Data

This evaluation uses a mixed method approach to evaluating Vermont's 2006 HCAA. Interviews with key informants were used to clarify the historical context, policies, and practices involved with implementation and to gain insight around lessons learned that might be helpful as other states consider implementing health care reform. Primary and secondary data sets are used to assess the impact of the health care reforms on public, private, and self-insured coverage options, enrollment, premiums and other out-of-pocket costs, program administrative costs, and related measures. Data sets used to conduct the analyses in this report include:

- Administrative data on enrollment,
- The 2005, 2008, and 2009 VHHIS,
- The Current Population Survey (CPS),
- The 2006, 2008 and 2009 Medical Expenditure Panel Survey
- Department of Vermont Health Access (OVHA) revenue and expenditure data

Key Findings

As with any significant piece of health reform legislation, there have been challenges with implementation of the 2006 HCAA. However, findings presented in this report suggest that since the 2006 HCAA was enacted and implementation began, the percentage of uninsured Vermonters has been reduced significantly. Key findings include:

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- **The percentage of uninsured Vermonters has decreased.** Between 2005 and 2009, the percentage of all residents with some type of insurance coverage in Vermont increased by 2.2%, bringing the percentage of residents covered by insurance up to 92.4%. Among Vermonters less than 65 years of age (i.e. excluding the Medicare eligible population), the percentage with coverage increased 2.4%. During this time period, insurance coverage in Vermont has increased more rapidly than it has in other New England states, with most of the increase in Vermont's coverage coming through increases in public coverage. These trends suggest that Vermont's health reform programs may be a factor in the observed increases in insurance coverage for the state.
- **Most of the increase in coverage occurred due to an increase in the propensity to take up coverage rather than demographic shifts.** In particular, there was a substantial increase in the propensity to enroll in public coverage between 2005 and 2009 (4.4%). This is consistent with the enactment of the public health insurance expansions in 2006. There was also a decline in the propensity to enroll in private insurance in Vermont between 2005 and 2009 of about 1.9%. This decline was greater than the corresponding change in New England but not much greater than the national change (1.5%). The larger decline in the propensity to take up private coverage conditional on characteristics in Vermont is consistent with the existence of some coverage crowd-out.
- **Enrollment in the new Catamount Health program increased sharply and steadily during the initial months.** By June, 2010, a total of 11,867 people were enrolled in Catamount Health. Most of these enrollees receive premium assistance. Only 16.2% of enrollees have family incomes above 300% FPL and do not receive premium assistance.
- **Outreach campaigns have been effective.** Although Catamount Health has played a role in reducing the percentage of uninsured Vermonters, it has not been the only factor. Also important has been an aggressive outreach campaign that has 1) spread knowledge about both new and existing programs and 2) facilitated enrollment in state programs. Our analyses show that participation in public programs rose substantially among those who had been eligible for public coverage before the recent expansions. Insurance coverage rates increased 5.2% among those who had always been eligible for public insurance. In comparison, coverage rates increased more moderately among those who were newly eligible (0.3%) or never eligible (0.4%) for public coverage. These data suggest that increased outreach to populations already eligible for public insurance in Vermont may have led to an increase in enrollment into existing Medicaid programs. Outreach to those who were eligible for VHAP but may not have known about the program (or may not have thought they were eligible) appears to have been particularly effective, as enrollment in traditional Medicaid increased by 9%, while enrollment in VHAP increased by 39%.

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- **There have been some barriers to enrollment, but modifications to the reforms have been made to address these barriers.** Although insurance coverage has increased, many advocates indicated barriers to enrollment in the existing system. Some of the barriers to enrollment cited by key informants include: the affordability of the plan, particularly for those individuals who do not qualify for premium assistance, the 12-month waiting period for coverage, and the difficulty of the eligibility determination and enrollment processes. Implementation of the HCAA, however, has been viewed as an ongoing reform process, and at least 5 bills have been passed to date to modify and clarify the original HCAA health reforms and address these barriers. With the planned oversight built into the HCAA and the upcoming implementation of federal health reform, it is expected that there will be additional changes to the reform efforts in the coming years.
- **Churning among Catamount Health enrollees is higher than expected.** While enrollment size has been steady, the analysis of enrollment churn found that very few people stay continuously enrolled in the program. The average duration of enrollment is around 7-8 months. This churning finding has implications for the cost of the program in terms of administrative expense as well as for the continuity of care received by program enrollees. This is an area that requires further research and has implications of federal health insurance reform.
- **The program, as currently funded, is not financially sustainable.** The state began to acquire revenues for health reform prior to the implementation of most programs covered. This was done in part to build up a reserve to cover the costs of Catamount Health and other programs that require a lead time to be sustainable. As of December 2007, following the initial roll-out of CH, the Catamount Fund balance was approximately \$7.6 million. Since December 2007, the fund balance has declined as program revenues are not keeping pace with expenditures. Without legislative action during the 2010 session, the projected fund balance in August of 2010 would have been negative. The information presented here indicates that program sustainability as a function of premium expenditures versus tax and other revenues is not viable in the long term.
- **Although modifications will be needed to continue the programs in the future, stakeholders remain optimistic about the future of health reform in Vermont.** The programs are overall well supported by all stakeholders. Most feel that too much has been invested in these programs for them to be cut in the near term. However, most also agreed that there would be ongoing reforms and modifications to these programs in order to improve them and/or to help bring them within current budget realities. Federal health reform will also impact Vermont's programs, although the net result of this multi-faceted legislation is not yet well understood.

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II. INTRODUCTION

This report presents the results of a two-year comprehensive evaluation examining the effectiveness of Vermont's efforts to provide affordable coverage for uninsured residents and reduce healthcare costs through system changes. The evaluation is being conducted by the University of New England Center for Health Policy, Planning, and Research (CHPPR) with funding from the Robert Wood Johnson Foundation's (RWJF) State Health Access Reform Program.

The purpose of this study is to evaluate the effectiveness of Vermont's health reform policies in increasing access to comprehensive affordable health insurance coverage and, ultimately, access to quality health care. Our evaluation addresses two key dimensions of Vermont's comprehensive health reform:

- Health coverage affordability,
- Health coverage access, and
- Sustainability of the reform.

In addition, a qualitative process evaluation is included based on key informant interviews conducted in each year of the evaluation. We conducted interviews with a variety of stakeholders involved with the initial passage of the legislation and with implementation, along with those who represent groups affected by the reforms. These interviews enabled us to construct a thorough account of the history of the reforms and legislation development. They also gave us an understanding of stakeholder perceptions of the reforms and future directions.

We also present in this report a preliminary analysis of affordability and sustainability of Vermont's newly created health insurance programs. The affordability analysis uses the results of the 2005, 2008, and 2009 Vermont Household Health Interview Survey (VHHIS), comparable CPS data for New England and the U.S., and administrative enrollment data for Vermont's publicly subsidized health insurance programs. In addition, we use VHHIS findings to explore reform affects on access to health care for Vermonters. Finally, we examine data on employer sponsored insurance benefits to explore employer coverage during reform and use State revenue and expenditure data to make some predictions regarding sustainability of new programs.

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III. HEALTH REFORM IN VERMONT

HISTORY OF HEALTH REFORM IN VERMONT

Vermont has a long history of health care reform efforts. In his 1939 inaugural address, Governor Aiken said³:

A subject of nation-wide discussion today is that of health insurance and hospital insurance. Hospital insurance began in Vermont, and we the people of this state recognize full well that the health of our neighbors as well as of our own family is of vital importance to us.

We recognize that many people who should be getting medical care or hospitalization are not now receiving it. It is also an accepted fact that much improvement could be brought about through cooperative efforts by communities or possibly on a state wide basis.

There may be federal legislation concerning health insurance. Vermont wants no part in any plan that would permit political selection of doctors or the direction of their activities by the government. But we ought to be ready to cooperate either among ourselves, with the people of other states or with the federal government on any plan providing for cooperative and voluntary efforts to promote better health among our citizens.

Hospitals, doctors and laymen in Vermont are all working toward this end. It may be that some plan will be devised before this legislature adjourns that will appear practicable and will permit the broadening of our present sporadic efforts to a state wide basis. If such a plan is devised and legislation appears necessary to make it effective, I hope such legislation will be enacted.

The first broad-based efforts at reform began in 1973, with the appointment of a commission to “explore the need for regulatory authority over the health care delivery system in the state.”⁴ This commission made recommendations in the areas of cost containment and health planning. In concert with national planning efforts, the state implemented the planning recommendations in 1976 and 1977. In 1983, the state created a process to review hospital budgets.

³ January 5, 1939 Inaugural Address of George D. Aiken as it appears in the Journal of the Joint Assembly Biennial Session 1939. Available at:

<http://vermont-archives.org/govhistory/gov/govinaug/inaugurals/pdf/Aiken1939.pdf>

⁴ Vermont State Government Since 1965, University of Vermont, p. 374

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The first effort to address coverage issues was the Vermont Health Insurance Plan (VHIP), created by the legislature in 1988. VHIP's goal was universal access. A deteriorating financial picture led to a sharp reduction in program scope. As a first step, the state created the Dr. Dynasaur program, intended to expand coverage for children.

Originally, Dr. Dynasaur provided coverage for children up to age 7 in families up to 225% of poverty and pregnant women up to 200% of poverty, using state funds. Eventually the program was rolled into the state Medicaid program and was expanded to include children up to 18. Currently, Vermont covers children up to 300% of poverty. Children in families between 226% and 300% of poverty with no other insurance are covered under the CHIP program, while children in this income cohort with other coverage are covered as part of the state's 1115 Medicaid waiver.

Despite these early efforts, both costs and the number of uninsured continued to increase. Governor Richard Snelling appointed a Blue Ribbon Commission on Health Care in 1990. The Commission submitted a comprehensive set of recommendations to Howard Dean, who became Governor upon the death of Governor Snelling in 1991. Governor Dean submitted a bill to the Legislature incorporating the Commission's recommendations. This bill, which became Act 160, once more set the goal of universal access, although the mechanism by which it would be achieved was left open. The bill delegated responsibility for the design of two different approaches to a newly-created Health Care Authority, which was also given responsibility for much of the state's health planning and regulatory activities.

After several years of intense work, major health care reform was once more abandoned, but like the earlier reform effort, a small step was taken to expand access, in this case to low-income childless adults. This program, Vermont Health Access Program (VHAP), created under federal 1115 Medicaid waiver authority, ultimately provided coverage to almost 35,000 people. Initially, this program was funded solely from an increase in the state cigarette tax, but funding was ultimately integrated into the broader Medicaid program. The VHAP program also provided assistance with prescription drug costs, primarily to Vermonters on Medicare.

HISTORY AND BACKGROUND OF THE 2006 REFORM LEGISLATION

Setting the Stage for Health Care Reform: Vermont's History with Medicaid Expansions, Growing Public Demand, and Democratic Gains in the Legislature

By 2004, public interest and political will were continuing to build around health care reform in Vermont and across the nation. There was a sentiment among Vermont business owners and among the general population that rising health care costs were not sustainable. During the 2004 state elections the Democratic Party won control of Vermont's House of Representatives from the Republicans, who had controlled the House since 2001. The Senate remained under control of the Democrats. Many of the newly elected Democrats ran on a platform of health care reform and, thus, had a personal stake in making sure health care reform was taken up in the following legislative session.

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The Role of Collaboration in Spearheading Reform Efforts

Outside of the statehouse, several other groups were contributing to the health care reform discussion in Vermont. Coalition 21 was initiated in July 2004 by State Senator Jim Leddy and the Vermont Business Roundtable to develop a consensus on how to transform Vermont's health care system. The founders of Coalition 21 wanted to create a grass-root, broadly-based coalition to convene and find common ground. They initially agreed on three core statements of principle:

- We have a crisis in healthcare.
- Every Vermonter should have health insurance.
- We agree to participate and be open to dialogue and to ideas of others.

This Coalition, chaired by Stephan Morse, a former Speaker of Vermont's House of Representatives, included a wide variety of stakeholders including: AARP, the insurance companies, regional Chamber of Commerce organizations, Vermont Medical Society, business groups, Vermont Legal Aid and others. Although these stakeholders had different reasons for being at the table, they were all frustrated with the current health care system in Vermont. The Coalition, which was staffed by Vermont's Snelling Center for Government, developed a set of six core principles for Health Care Reform. These principles, which were unanimously embraced by the House Health Committee in January 2005, included the following:⁵

1. It is the policy of the State of Vermont to ensure universal access to and coverage for essential health care services for all Vermonters.
2. Health care coverage needs to be comprehensive and continuous.
3. Vermont's health delivery system will model continuous improvement of health care quality and safety.
4. The financing of health care in Vermont will be sufficient, equitable, fair, and sustainable.
5. Built-in accountability for quality, cost, access, and participation will be the hallmarks of Vermont's health care system.
6. Vermonters will be engaged, to the best of their ability, to pursue healthy lifestyles, to focus on preventive care and wellness efforts, and to make informed use of all health care services throughout their lives.

Coalition 21 disbanded in 2006 primarily because it was a consensus-based organization, and it was becoming increasingly difficult to form consensus around the specifics of health care reform.⁶ In particular, the group could not agree on the specifics of implementation and financing of this reform. Additionally, the coalition consisted of volunteers with limited staff resources. Its work was consequently taken over by the legislature. Nevertheless, the six principles enumerated by Coalition 21 formed the basis

⁵ Health Care Reform in Vermont: Hard Choices for Transformative Change An Overview of the work of Coalition 21 (2004-2006) Available at: www.snellingcenter.org/filemanager/download/11948/

⁶ Ibid.

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for, and were included verbatim, in both the vetoed 2005 bill and the successful HCAA of 2006.

Another key stakeholder group was formed in the fall of 2005 to develop political and public support for health reform. The Vermont Campaign for Health Care Security initially started with support from the Vermont Public Interest Research Group (VPIRG), Vermont National Education Association, AARP Vermont, and the Vermont State Employees' Association. By January 2006, the Campaign had grown to a coalition of 23 member organizations that included labor groups, consumer groups, minority rights groups, and many others. During the 2006 legislative session, it ran radio and print ads in favor of passing health care reform. This was likely a key factor in increasing public pressure and support for a compromise between the Governor and the legislature.

The 2005 Legislative Session: The Discussion on Health Reform Begins

Prior to this session, both chambers of the Vermont Legislature had Health and Welfare committees. The first priority of the new Democratic majority in the House of Representatives was to create a standing committee on Health Care Reform that would be able to focus entirely on reform efforts, while the renamed House Human Services committee worked on other related issues. The new committee would begin the dialogue on Health Care Reform and would work very closely with the Senate's Health and Welfare Committee. The House Health Care Reform Committee began meeting during the 2005 legislative session and developed and passed a health care reform bill, H.524, an Act Relating to Universal Access to Health Care in Vermont. During Health Care Reform discussions, the House and Senate committees worked together in a more fluid way than the two chambers had traditionally worked.

H.524 was the first attempt by the new Democratic majority in the House to pass health care reform legislation. This legislation intended to provide access to health coverage for all Vermonters by creating a new, publicly funded and managed program, called Green Mountain Health, to cover all uninsured Vermonters. The program was to have a defined benefits package, focusing on primary and preventive services. The debate in the 2005 session focused largely on how to finance the new coverage for the uninsured and, in particular, whether the healthcare system should be publicly financed through a new payroll tax. Little of the discussion addressed cost containment within the health care system.⁷ Republican Governor Jim Douglas vetoed the bill in June 2005, citing more than 20 "principal deficiencies".⁸ The Governor was particularly concerned about the financing of the bill, which included new payroll taxes. He also felt that a government-run system would limit choice and would not do enough to limit costs. An override of the veto, which required a two-thirds vote, was not attainable.

Although a health care reform bill was not signed into law in 2005, the 2005 legislative session was integral in beginning the legislative conversation on Health Care Reform that

⁷ Thorpe KE, Vermont's Catamount Health: A Roadmap for Health Care Reform? Health Affairs (<http://content.healthaffairs.org/?ck=nck>), 26, no. 6 (2007): w703-w705.

⁸Douglas J. Letter to Donald G. Milne, Clerk of the House of Representatives. June 22, 2005 Available at: <http://governor.vermont.gov/tools/index.php?topic=GovPressReleases&id=1360&v=Article>

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would eventually lead to passage of the Health Care Affordability Act of 2006. The bill contained an item to fund and establish a health reform commission, which the 2005 legislature eventually passed in a separate bill that created the Commission on Health Care Reform (No. 71 of the Acts of 2005). This Commission, which would hold hearings throughout the state on health care reform efforts, was led by two Democrats, Senator Jim Leddy and Representative John Tracy.

Public Engagement Process Helped to Develop Political Will

In the summer of 2005, the Commission on Health Care Reform held six town meetings throughout the state to discuss health care reform issues with the public and to listen to public comment. The Commission contracted with the Snelling Center to provide support for this public engagement process. The legislators on the Commission went to towns, met with business and community leaders, observed focus groups with different stakeholders (e.g. employers, health care professionals) and attended a public hearing at night. The intent of these meetings was both to allow the legislators to share what they knew about the status of the health care system in Vermont and to provide a venue for the public to provide feedback to the legislators on their top concerns and priorities regarding health care reform. The meetings taught the legislators that the messages they were sending out about health care reform used too much jargon and were not clear enough; they found that they would need to use language that appealed to all Vermonters, insured or not, in order to bring about successful reform. The meetings also focused heavily on the importance of comprehensive benefits for any new State offering.

Another lesson learned through this process was that rather than focusing on how to finance reform, the average citizen was more interested in what the new programs would be paying for. The Snelling Center produced a detailed report on the public engagement process that was useful feedback for the next legislative session.⁹ The Governor also held a series of summits during the same time period. One of the outcomes of these meetings, along with the Snelling Center's report, was that the Governor and the legislators confirmed that there was public will to do something in the health care reform arena.

Signing of the Global Commitment Waiver Provided Mechanism to Fund Health Reform

Vermont has a long history of using federal waivers to provide flexibility for its Medicaid expansion programs. In 1995, Vermont was granted a Section 1115 waiver to extend coverage under the VHAP program. Federal Medicaid waivers give the federal Centers for Medicare and Medicaid Services (CMS) the authority to allow states, within certain restrictions, to expand health coverage programs beyond the traditional eligibility for Medicaid populations, provide services that are not typically covered, or use innovative service delivery systems while maintaining a federal match of state funds allotted for these programs. Section 1115 waivers are for research and demonstration grants to test policy innovations at the state level. The projects are typically approved for 5 years and must maintain budget neutral status in terms of federal funding.

⁹ [Snelling Center Report on Vermont Legislature's Public Engagement Process](http://www.snellingcenter.org/filemanager/download/3307) Available at: www.snellingcenter.org/filemanager/download/3307

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In the fall of 2005, Vermont's existing 1115 waiver was replaced by a new Section 1115 waiver, which provided the state with federal authority to continue Medicaid expansion programs developed under the previous 1115 waiver (e.g. VHAP), along with the existing 1915 home and community waivers (support services for people with developmental disabilities, brain injuries, etc). This new waiver was known as the Global Commitment to Health Waiver. Like all 1115 waivers, it imposed a cumulative cap on federal Medicaid funding and, in exchange for increased program flexibility, gave the state the authority to alter pieces of the benefit package, to increase participant cost sharing, and to implement new cost-control strategies. The Global Commitment Waiver also allowed the state to operate its own public managed care entity. The state (the Agency of Human Services) pays a per-enrollee premium to the managed care entity (the Department of Vermont Health Access). For that premium DHVA agrees to ensure provision of medical services to the enrollees.

The Waiver was based upon 2004 spending levels. This was a good base year for Vermont because it had the highest spending compared to prior years. At the time, health care spending was increasing by 12% a year. CMS wanted to project 7% increases each year in calculating waiver funds. The compromise, which was used to calculate the waiver levels, was a 9.9% increase in health care spending each year.

The Global Commitment Waiver was one component of comprehensive health reform in Vermont. Under the Waiver, the State secured some additional flexibility for its Medicaid program that allowed it to experiment with new options for improving access to care. However, the waiver did include a requirement that the state seek CMS approval to add new populations. After the HCAA was passed in May, 2006, the state asked that the waiver include federal matching for Vermonters up to 300% of the federal poverty level (FPL) for the Catamount Health Plan created in the HCAA which provides subsidized premium assistance for individuals and families up to 300% FPL. However, approval was only granted to 200% FPL. This would prove to be one of the first stumbling blocks in Vermont's reform efforts because it restricted the level of federal funding available to fund Catamount. Those involved in developing the legislation were hopeful that CMS would grant a waiver up to 300% FPL because Massachusetts was granted this latitude in their waiver. However, this change was not made until December, 2009, when the new federal administration approved a waiver amendment to include a federal match up to 300%.

2006 Legislative Session

During the 2006 Legislative Session, the Democrats realized that the type of reform proposed in H.524 would not be enacted under Republican Governor Douglas' administration without the votes needed to override a veto. They could wait for a new administration or compromise. While some single-payer advocates did not want to compromise, most within the legislature realized that without compromise nothing would get passed and the problems of the health care system would remain unaddressed. The hospital and provider community also remained wary of reform and were concerned that physicians be reimbursed at reasonable rates in any newly proposed programs. Some business groups, such as Chambers of Commerce, were concerned, as well, about the

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implications of government health care expansions in terms of government spending and tax burdens for businesses.

Dr. Ken Thorpe from Emory University was retained by the Commission to provide technical assistance to the debate on health reform. Dr. Thorpe helped to refocus the debate from how to finance health insurance to how to reform the broader health care system. The focus of reform efforts shifted to providing better primary and preventive health care that meets the chronic medical needs of patients and reducing barriers to care. The idea of making health care more affordable, improving delivery of care, improving quality of care, and expanding health information technology capabilities were important both to the Republican Governor and to the Democratically-controlled legislature. This shift in focus from talking about financing additional coverage to emphasizing delivery system reform such as preventive and primary care promotion, chronic disease management, and developing a plan with comprehensive benefits proved to be an underpinning of the compromise that was achieved in the HCAA. The legislators embraced the Blueprint for Health, a plan for a comprehensive and statewide system of care to address chronic disease launched in 2003 by Governor Douglas, and wanted the bill to codify it in statute so that the Governor would want the bill to pass. Act 191 of 2006 codified the Blueprint as the state's plan for addressing chronic care in Vermont and added prevention of chronic disease as a primary Blueprint goal. This targeted change in the area of chronic disease prevention and treatment proved to be an area that people across the political spectrum in Vermont could agree on because of its potential to improve the quality of care available in the state while simultaneously reducing the growth in costs (e.g. by treating chronic conditions earlier and preventing costly hospital admissions).

Rising Costs and Compromise

As the discussion continued in Vermont, policymakers took note as Vermont's neighbor to the south, Massachusetts, passed its own health care reform bill. In the minds of some legislators, the Massachusetts bill showed that compromise between a Republican governor and Democratic legislature was possible and reasonable. The Massachusetts reform included a tax on employers who do not provide insurance to their employees. The idea that all businesses should have a responsibility to contribute to health insurance payments began to gain traction in Vermont.

Unlike Massachusetts, however, legislators in Vermont were determined that their plan must be comprehensive and not just focus on access. They felt strongly that State funds not be used to subsidize enrollment in a high deductible plan or subsidize enrollment in a plan that did not include appropriate chronic and preventive care. Vermont was also unwilling to pass an individual mandate, requiring that all residents purchase insurance or pay a tax. Instead, a provision was passed requiring the legislature to consider a mandate in 2010 if 96 percent of Vermonters do not have insurance coverage by then.

Although both the legislature and the Governor wanted to get something passed, differences remained between the two in what a final health care reform bill should contain. Both acknowledged that each side would have to compromise. One of the

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compelling reasons for compromise that all sides appeared to agree on was the specter of ever increasing health care costs that were unsustainable for individuals, employers, and the State. The concept of a “cost shift,” that those with insurance are already paying for those without insurance through higher hospital fees and health insurance premiums, was widely promulgated on both sides of the debate. Similarly, statistics citing the high proportion of Vermonters already receiving State assistance through Medicaid, Dr. Dynasaur and other programs were used to show that the issues involved with health care reform affect everyone, not just the uninsured. The following quotes show that this concept of all Vermonters sharing in the cost of the uninsured was understood on both sides and likely played a role in the eventual compromise:

“...when people do not have primary care, we all pay the bill.”¹⁰
– John Tracy, Former State Representative (D)

“If we don’t reduce the cost of care, all of our pockets are going to be empty.”¹¹
– Governor Jim Douglas (R)

Nevertheless, Governor Douglas remained adamant that health care reform in Vermont should not be based on expanding a state-run plan, such as Medicaid. He wanted any new insurance plan to be run by private insurance companies so that the State would not carry the associated risk. Many of the legislators were not happy about the implications of a privately-run plan, particularly because this would add costs and complicate the application process by requiring residents to apply for eligibility through the state and then sign up with the insurance companies. However, acknowledging that the Governor would not back a state-run plan, this ended up being a point of compromise. The HCAA created Catamount Health Plan as a private sector plan which would be publicly subsidized for those eligible based on income. In the final bill, the legislature included a provision that says that no sooner than October 1, 2009, the legislature would evaluate costs and enrollment to see if the privately run program was more or less cost-effective than a publicly run program would have been¹².

¹⁰ Health Care Reform in Vermont: Hard Choices for Transformative Change An Overview of the work of Coalition 21 (2004-2006) – pg 7; Available at: www.snellingcenter.org/filemanager/download/11948/

¹¹ Comprehensive Health Care Reform In Vermont: A Conversation With Governor Jim Douglas (2007) Health Affairs – web exclusive, w699 Available at: <http://content.healthaffairs.org/cgi/content/full/26/6/w697?ijkey=fdc671211b7efed39ae1a51c351dcd95f23d6750>

¹² In September 2009, the Vermont State Government contracted with UNE/CHPPR to evaluate the Catamount’s administrative costs and affordability. The Catamount program’s system of premium subsidies, sliding with enrollee FPL, was found to be comparable with similar premium subsidy levels used in neighboring Massachusetts. Ten alternative options for re-structuring the Catamount program’s administrative functions were assessed. Options with the highest potential for administrative expense savings over current levels were: migrate the full enrollment process to Vermont Medicaid; and/or convert the Catamount Health Plan design from a Preferred Provider Organization (PPO) design to a self-insured ASO (administrative services only) plan design. The study’s findings were presented to the health insurance subcommittee of the Vermont legislature in February, 2010.

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The Governor also pressed for the employer-sponsored insurance (ESI) component of the bill, which would shift people from state programs (VHAP, Catamount Health) to their employer-sponsored insurance plan and subsidize premium payments if it is cost effective for the state to do so. Although many in the legislature opposed this component, it was passed as part of the compromise. The Governor's side did have to compromise on some aspects of the reform. For example, his administration was initially opposed to any increase in any type of taxation to finance the reform. In the end, the agreement to allow both the increased tobacco tax and the employer assessment reflects the give and take process that allowed this legislation to pass.

As the Catamount Health plan began to take shape, the state relied on the expertise of two health policy experts in the development of enrollment models. The legislature contracted with Dr. Thorpe, and the administration contracted with Dr. Sherry Glied, a health economist from Columbia University. Both consultants developed independent projections of take-up rates at different premium and income levels. Both consultants started with the same information (the 2005 Vermont health insurance survey), but took different approaches to building their estimates. Dr. Thorpe's model was based on the work of Congress' Joint Committee on Taxation. His model was based on net premium as a percent of beneficiary income (net of any subsidy) and subsidy as a percent of full premium. Dr. Glied used a take-up matrix model using literature-based take-up rates applied to groups defined by eligibility and income categories.

Once the basic outlines of Catamount Health were established, both models agreed that about 50% of eligible Vermonters under 300% of poverty would be likely to purchase coverage once the program was fully phased in and operational. There was a great deal of discussion in the legislature about what the reforms should look like and what would be acceptable to the Governor (e.g., how far the reforms could go and still be signed into law by the Governor). There was also a lot of discussion about who would support the reforms and whether, for the Democrats, a veto would be a better outcome politically. One indicator of how difficult these legislative discussions were is that the version that was ultimately passed was initially going to be vetoed, so the legislature amended it before it was acted on by the Governor. This is why there are two acts to the reform.

In the end, comprehensive health care reform legislation was passed in Vermont as a result of collaboration, compromise, and a focus on controlling costs. Collaboration was possible because of the small size of the state, the familiarity between politically disparate groups and the ability of a few leaders to bring disparate groups together around a common set of guiding principles. Compromise was necessary in order to put together a set of reforms that were amenable to the democratically controlled legislature, the Republican Governor and the various stakeholders supporting health care reform. Finally, this compromise was possible because of a fundamental shift in the framing of the health care issue from focusing on how to cover the uninsured to a focus on promoting preventive, primary and disease management services in order to control costs for everyone in the system. This reframing of the issue allowed everyone to participate in the discussion, from the insured seeing their co-payments increase every year to the employer watching annual premiums go up.

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DESCRIPTION OF NEW PROGRAMS

The 2006 HCAA had three primary goals:

1. Increase access to affordable health insurance for all Vermonters;
2. Improve quality of care across the lifespan; and
3. Contain health care costs.

To achieve the first goal, the HCAA created two health insurance programs intended to provide access to affordable insurance to the state's uninsured.

- The Catamount Health Insurance Program (Catamount Health) is a state-designed and subsidized health insurance program intended to provide affordable health insurance coverage to people who are not offered coverage through their employer but who exceed the income limitations for current state and federal Medicaid programs.
- Under the Employer-Sponsored Health Insurance (ESI) Premium Assistance Program, the State provides financial assistance to certain uninsured employees to help them take advantage of insurance offered by their employer.

There are two pieces to the Catamount Health plan. First, it is similar to a “traditional” insurance product with specific benefits that any uninsured Vermonter, without access to comparable employer sponsored insurance, can purchase at full cost. Additionally, there is a premium assistance component to Catamount Health, allowing those with lower incomes to purchase the insurance product with assistance from the state to make it more affordable, similar to the subsidized health insurance exchange concept. To be eligible for Catamount Health, Vermont residents must be uninsured for the previous 12 months or have lost insurance through a qualifying event (e.g., lost job, divorce, no longer eligible for dependent coverage under parent's insurance, no longer eligible for other state insurance programs).

Under Catamount Health, private insurers offer a comprehensive insurance plan to uninsured Vermont residents who do not have access to insurance through their employers. MVP Health Care and Blue Cross Blue Shield both agreed to offer this product, giving individuals enrolling in Catamount Health a choice of two plans. The benefit design, for the most part, was codified in statute. The Plan is modeled after a preferred provider organization plan and originally had a \$250 deductible and \$800 out of pocket maximum (the deductible was raised to \$500 in 2010). The plan was intended to be similar to a “typical” insurance plan in Vermont, but there was a great deal of discussion about what this meant. One of the requirements for benefit design was that preventive care and chronic disease management services had to be covered and carriers could not require cost sharing for these services. There is also no deductible for prescription drug coverage (although there are significant copayments). The state was able to secure lower premium costs compared to equivalent benefit plans on the private

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market due to provider reimbursement rates that are lower than commercial rates, although reimbursement rates remain 10% higher than Medicare rates, and because of an expectation that those enrolling in Catamount Health would be younger and healthier than the currently-insured.

The cost of enrollment in Catamount Health is based on a sliding fee scale, ranging from \$60 per month for those with incomes up to 175% of the federal poverty level (FPL) to \$452 at full cost for those with incomes above 300% FPL. The current costs of insurance by income (as % of federal poverty level [FPL]) are presented in Table 1.

Table 1: Cost of Catamount Health Premiums by Family Income Level (as % FPL)

Income (as % FPL)	Cost per person 2009	Cost per person 2010
Up to 200%	\$60	\$60
200-225%	\$110	\$122
226-250%	\$135	\$149
251-275%	\$160	\$177
276-300%	\$185	\$205
Over 300%	Full price \$393.00	Full price \$452.08

The state uses Medicaid funds to subsidize the difference in premiums between full cost enrollment and the fee paid by the enrollee. Premiums for those receiving premium assistance have increased twice since implementation of the program. First, the legislature raised the premiums in 2008 to help make the program sustainable and simultaneously, a \$400 earned income disregard was put into place for Catamount Health Premium Assistance and Catamount Employer Sponsored Insurance Assistance (in addition to the existing \$90 per month earned income disregard and up to \$175 per child per month of childcare costs). This \$400 disregard only applies to those between 200% and 300% FPL to reflect costs associated with having an earned income and also results in increasing the percentage of participants who fall below 200% FPL in final income determinations (making their costs eligible for federal match to address the lack of CMS approval up to 300% FPL). The second increase in premiums resulted from rate filing increases posted by both MVP and BCBS in early 2010. It should be noted that as of June, 2009 premiums for those below 200% FPL were reduced back to the pre-July 1, 2008, level to comply with the maintenance of effort requirements in the federal stimulus bill and that these enrollees share of the premiums remained unchanged even after the insurance rate filings. While the income disregard is still intact as of today, the 2010 PPACA Federal Health Reform act requires all States to use the same Modified Adjusted Gross Income eligibility determinations for Medicaid and the health insurance exchanges as of January 1, 2014, so it is unclear whether Vermont will be able to maintain these disregards.

The ESI Premium Assistance Program is designed to lower the costs to the state of expanding health insurance by subsidizing enrollment of individuals into their employer's health plan in cases where it would be more cost effective to do so than to pay for VHAP or Catamount Health.

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- Under the ESI Premium Assistance Program, uninsured Vermonters who would otherwise be eligible for VHAP are required to purchase their employer's insurance plan if certain criteria are met. These include: the plan must be as good as the typical plan of the four largest insurers in the small group and association market and enrolling the individual in ESI rather than VHAP is cost-effective to the state. The state will continue to provide secondary benefit coverage, or wrap-around coverage, so the overall benefits do not change.
- Uninsured Vermonters who would otherwise be eligible for Catamount Health are also required to purchase a plan offered by their employer if the employer's plan is roughly equivalent to Catamount Health (determined by comparing scope of benefits - has to cover both hospital care and doctor visits - and a \$500 individual in-network deductible) and if enrolling the individual in ESI rather than Catamount Health is cost-effective to the state (cost to subsidize employee share of premium is less than cost to subsidize Catamount). Unlike VHAP ESI, the Catamount wrap is limited to any cost sharing associated with the management of a chronic disease.

To address goals 2 and 3 of the HCAA (improving quality of care across the lifespan and containing health care costs), the HCAA also codified the Blueprint for Health, a chronic care prevention and management program. The Blueprint, which was launched in 2003, was expanded and redefined by the 2006 HCAA and again in legislation in 2007. It focuses on preventing and managing chronic conditions to improve quality of care and reduce health care costs.¹³ The Blueprint is currently in the pilot stage but is moving toward statewide expansion. Integrated health service pilots have been implemented in three communities combining the patient centered medical home concept with locally driven community health teams and HIT infrastructure that supports guideline based care, population reporting and health information exchange. All three major commercial insurers and Medicaid collaboratively finance the community health teams and incentive payments to primary care providers based on quality scores.

The program is intended to help primary care providers operate their practices as advanced medical homes that offer coordinated care supported by local services, health information technology tools, and provider reimbursement mechanisms.¹⁴ The Blueprint model targets six change areas: Individual Vermonters, Provider Practice Teams, Communities, Information Technology, Health System, and Public Health System. The initial focus of Blueprint was on diabetes, but has expanded to address additional chronic diseases, basic health maintenance, and prevention. In addition to codifying the Blueprint for Health, the 2006 HCAA also required OVHA to develop a chronic care management program, consistent with Blueprint standards, for Vermonters enrolled in Medicaid, Dr. Dynasaur and VHAP. The statewide expansion phase hinges on insurer participation, including Medicare, so Vermont is counting on being selected for the

¹³ Conis, Elena. "Vermont's Blueprint Chronic Care Initiative". *Health Policy Monitor*, November 2008. Available at <http://www.hpm.org/survey/us/a12/1>

¹⁴ Vermont Blueprint for Health, 2009 Annual Report, produced by Vermont Department of Health, January, 2010. Available at: http://healthvermont.gov/prevent/blueprint/documents/Blueprint_AnnualReport_2009_0110rev.pdf

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Medicare Multi-Payer Advanced Primary Care Practice Demonstration pilot program to be implemented in 2010.

During the legislative discussions around the 2006 HCAA, there was relatively little discussion about financing. Rather, most of the discussion was around the programs described above. Despite this, the HCAA is funded through a variety of sources and uses some creative funding mechanisms. The Catamount Health Fund was established to be the source of funding through which all revenue streams would be funneled in order to pay for Catamount Health Premium Assistance, ESI Premium Assistance Programs, the Blueprint for Health and other initiatives in the legislation. Funding for VHAP ESI does not come from the Catamount Fund.

As mentioned earlier, when the legislation was initially passed the state expected more than half of the funding to come from matching funds provided by the federal Medicaid program under Vermont's Global Commitment to Health Waiver. Vermont anticipated that the federal government would allow matching funds to help pay for premiums of individuals up to 300% FPL; however, the Centers for Medicare and Medicaid Services (CMS) only approved matching of federal funds up to 200% FPL, until the current Federal administration approved the match up to 300% in 2010. As a result, the State had to allocate additional general fund revenues to make up the difference for the first few years of the program. There is a provision in the legislation that enables the state Emergency Board¹⁵ to cap enrollment in the premium assistance programs if sufficient funds are not available to sustain the programs. This option has not been implemented to date.

The Global Commitment Waiver gave Vermont a 5-year cumulative cap on spending. A multi-year cap, while providing some certainty in the future, could pose difficulties as health care costs rise. In particular, as new procedures become available, the use of such procedures and their associated costs could result in a significant rise in health care costs. However, in the implementation phase, Vermont focused on aggressively managing the money. For example, although gross spending for pharmacy increased, net spending on pharmaceuticals went down due to a supplemental rebate program put in place by the state and aggressive efforts to promote the use of generics. Another example of the state aggressively managing its money is that the state signed a diabetic equipment procurement contract that saves millions of dollars each year. Other sources of revenue to the Catamount Health Fund include a portion of the state's tax on cigarettes and other tobacco products as well as an assessment on employers not providing insurance to employees.

The employer assessment is a quarterly fee collected by the state Department of Labor on employees who are not either not offered insurance or who are offered coverage but decline it AND who are uninsured. This assessment ensures that all employers are responsible for helping to cover Vermonters, either by providing insurance coverage to their employees or by paying the employer assessment. The assessment, which began on July 1, 2007, started at \$91.25 per quarter (\$365 per year) per full time equivalent. To

¹⁵ The Emergency Board includes the Governor and the four chairs of legislative money committees

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ease the burden on employers, 8 full time equivalents (FTEs) were exempt from the assessment in fiscal years 2007 and 2008. This exemption dropped to 6 employees in FY 2009 and to 4 employees in 2010. Certain seasonal or part-time employees are exempted from the calculation of FTEs. The assessment increased to \$101.74 per FTE per quarter as of January 1st, 2010.

The 2006 HCAA also contained some other interesting provisions, including:

- *Potential individual insurance mandate.* If less than 96% of Vermont's population is insured by 2010, the health reform commission was charged with determining needed analysis and requirements for implementing a state health insurance mandate on individuals. However, with the individual mandate included in federal reform, this exploration may not be worth the cost.
- *Funding for Outreach and Enrollment Study.* Those drafting the bill knew that in order to meet the 96% insured goal it would require significant outreach efforts. The legislation provided funding for the Bi-State Primary Care Association to conduct a study and provide recommendations for outreach and enrollment strategies. Out of this work came a comprehensive marketing strategy including a rebranding of all state-supported programs (Green Mountain Care) and an aggressive outreach campaign using television, radio, internet and print media.
- *Decreases in VHAP and Dr. Dinosaur premiums.* Due to concerns about affordability, premiums for children enrolled in the Dr. Dinosaur program were decreased by 50% and premiums for adults enrolled in VHAP were decreased by 35%.
- *Immunizations.* In recognition that immunizations are one of the most cost effective public health strategies for prevention of disease, Act 191 included the creation of a new program through the Department of Health with the ultimate goal of providing immunizations to all Vermonters across the lifespan at no cost when not otherwise reimbursed.
- *Consumer Health Care Price and Quality Information Systems.* This portion of Act 191 included a requirement that health insurers file Consumer Information Plans describing their proposed procedures for providing members with information about quality, costs, and discount policies using a phased in approach. The concept behind the inclusion of this item is that informed consumers can make better health care decisions leading to improved quality and decreased costs.
- *Healthy Lifestyles insurance discounts.* Vermont's individual and small group markets are community-rated, and therefore insurance carriers could not vary costs for different populations¹⁶. However, Act 191 gave BISHCA the authority to adopt regulations permitting insurers to establish premium discounts or other financial incentives for those insured in the individual and small group markets who participate in health promotion and disease prevention programs.
- *Cost Shift Initiatives.* The cost shifts referred to here occur when premiums or medical charges paid by those with insurance, particularly commercial insurance, are increased in order to offset losses attributable to the uninsured, Medicaid and Medicare. Act 191 authorized BISHCA to convene a Cost Shift Task Force to make

¹⁶ Other than age-rating in the individual market by for-profit insurers

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recommendations regarding needed changes to ensure reductions in the cost shift such that provider charges and insurance premiums would be reduced or, at least, grow at a slower rate. This task force has made several recommendations, such as standardizing hospital bad debt and free care policies.

- *Local Health Care Coverage Pilot.* This provision provided funds to support a planning grant of \$100,000 to one community for the purpose of establishing a local initiative to provide health care coverage for their region or geographic area.

Additional Legislation Passed Since 2006

Since the passage of the 2006 HCAA, six additional bills have been developed and passed to modify the 2006 bills. These bills clarify the 2006 legislation and make important changes that affect implementation of programs and eligibility for programs among potential participants.

Table 2: Supplemental Health Reform Legislation Passed After 2006 HCAA

Bill	Clarifications/Modifications to 2006 HCAA¹⁷
<p>Act 70 of 2007 <i>An Act Relating to Corrections and Clarifications to the Health Care Affordability Act of 2006 and Related Legislation</i></p>	<ul style="list-style-type: none"> • Clarified eligibility and operations for Catamount Health and existing Medicaid programs • Clarified Catamount Health provider reimbursement methodology • Moved the contractual relationship for the state’s health information exchange organization, Vermont Information Technology Leaders (VITL), to the Department of Information and Innovation • Also, gave VITL authority to establish the Health Information Technology Fund, a loan and grant program intended to promote health care information technology, including assistance to providers purchase electronic health record systems. • Changed the treatment of part-time and seasonal employees within the employer contribution assessment
<p>Act 71 of 2007 <i>An Act Relating to Ensuring Success in Health Care Reform</i></p>	<ul style="list-style-type: none"> • Provided a framework for state’s outreach and enrollment efforts • Established eligibility for VHAP to be effective the date the agency receives the application • Limited premium assistance for Catamount Health plans to the amount of assistance for the lowest priced plan • Refined the uses of the Catamount Fund • Established a new Blueprint for Health director position • Created integrated medical home pilot projects within the Blueprint • Required BISCHA to develop a regulatory approach for Blueprint carrier participation if necessary • Moved Blueprint statewide implementation deadline from 2009 to 2011. • Required the secretary of administration to submit an annual legislative report that assesses the alignment between the state employee’s health plan and the Blueprint. • Required VITL to develop a pilot program to assist provider practices in implementing electronic health records. • Established a work group to study and make recommendations on the advisability of eliminating the requirement that an advance practice nurse work in a collaborative practice with a physician. • Required BISCHA to survey health insurers to determine reimbursement

¹⁷ State of Vermont Agency of Administration. Overview of Vermont's Health Care Reform. http://hcr.vermont.gov/sites/hcr/files/Revised_Vermont_HCR_Overview_October_08__0.pdf. Accessed June 2, 2009.

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	for primary care health services, mental health care providers, and other non-physician health care providers.
Act 203 of 2008 <i>An Act Relating to Health Care Reform</i>	<ul style="list-style-type: none"> • Refined Catamount Health Plans by <ul style="list-style-type: none"> ○ allowing people with very high deductible plans (\$10,000 deductible or greater) on the individual market to purchase Catamount Health; ○ allowing people who lose insurance coverage due to reduced work hours to enroll in Catamount and Medicaid expansion plans without 12 month waiting period; ○ clarifying pregnancy is not a pre-existing condition ○ providing amnesty window for pre-existing conditions through Nov 1, 2008. • No later than February 1, 2009, the secretary of human services shall apply to the federal Centers for Medicare and Medicaid Services for a waiver amendment to allow Vermont to shorten the waiting period for coverage under Catamount Health and the Vermont health access plan to six months from the current 12 months. • Changed rule that requires small businesses to enroll at least 75% of employees by lowering criteria to 50% for businesses with 10 or fewer employees. • Expanded insurance carriers' purview to offer discounted products (e.g. split benefit design plans) to beneficiaries making healthy lifestyle choices. • Other provisions to move state towards healthier lifestyles.
Act 204 of 2008 <i>An Act Relating to Managed Care Organizations, the Blueprint for Health, and Immunizations of Children Prior to Attending School and Child Care Facilities, and the Immunizations Registry</i>	<ul style="list-style-type: none"> • Requires that all health insurance plans available in VT be consistent with Blueprint. • Directs managed care organizations to establish chronic care programs consistent with the Blueprint. • Establishes the Blueprint Medical Home Pilot projects with the requirement of a pilot design and evaluation committee and BISCHA enforcement authority over carrier participation. • Enhances state immunization programs.
Act 61 of 2009 <i>An Act Relating to Health Reform</i>	<ul style="list-style-type: none"> • Reduced threshold for very high deductible exemption (see Act 203 above) to \$7500 for individual and \$15000 for family plans. • Created exemption for self-employed who lose their business (e.g. bankruptcy) from 12 month waiting period for Catamount eligibility. • Designated depreciation as allowable business expense for income calculation under Catamount, VHAP and ESIA programs.
Act 128 of 2010	<ul style="list-style-type: none"> • Requires Legislative Health Care Reform Commission to hire consultant to design three design options: <ul style="list-style-type: none"> ○ Government-administered and publicly financed "single-payer" health benefits system, decoupled from employment and allowing private insurance coverage only for supplemental health services. ○ Public health benefit system administered by state government, allowing individuals to choose between the public option and private insurance coverage. ○ Another option to be determined in consultation with the Commission • Established Primary Care Workforce Development Committee to develop long-term Strategic Plan for ensuring necessary workforce • Requires pharmaceutical manufacturers to annually disclose to the Attorney General, the physician's name and amount of drug samples provided to that physician • Requires health insurance plans to cover at least one 3-month supply per

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	<p>year of tobacco cessation medication, including over-the-counter treatments, if prescribed by a physician</p> <ul style="list-style-type: none"> • Requires the attorney general to report to the legislature regarding the results of the attorney general’s initiative on the prevention of obesity. • Requires restaurants or similar retail food establishments that are part of a chain with 20 or more locations doing business under the same name to disclose the number of calories contained in the standard menu items. • Requires health insurance plans to cover general anesthesia for children under 8 if they cannot be treated in an outpatient setting • Imposes hospital budget caps to ensure that the system-wide increase shall be lower than the prior year’s increase, and the total system-wide net patient revenue increase for all hospitals shall not exceed 4.5 percent in fiscal year 2011 and shall not exceed 4.0 percent in fiscal year 2012. • Insurance Carrier Rates • Requires the state to be more aggressive in reducing health insurance rate increases, allows the state to request more detailed reporting from insurers as part of the rate-filing process, and extends the minimum loss ratios required under the new federal Health Care Reform Act to insurers subcontracting to cover mental health conditions. • Requires DVHA to develop strategic plan to implement a pilot to test payment reform methodologies to manage the total costs of the health care delivery system in a region, improve health outcomes for Vermonters and provide a positive health care experience for patients and providers. • Expands the Blueprint for Health to at least two primary care practices in every hospital services area no later than July 1, 2011, and no later than October 1, 2013 to primary care practices statewide whose owners wish to participate • No later than January 1, 2011, health insurers and hospitals will be required to participate in the Blueprint for Health as a condition of doing business in this state. Doctors and other health care professionals are encouraged to participate
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LESSONS FROM OTHER STATES & IMPLICATIONS OF FEDERAL HEALTH REFORM

Just as we hope this evaluation will provide insight to policymakers in other states struggling with health care reform, Vermont’s policymakers have been informed by the experiences of other states during the initial development of legislation and during implementation of the reforms. We expect that, as Vermont continues to modify its approach to health care reform, the experiences of other states will continue to provide insight around approaches that have worked, those that have not worked as well, and what issues the state should be aware of as it makes future health care reform choices. Additionally, the passage of federal health reform in 2010 will undoubtedly affect the future of Vermont’s health reform efforts but the full implications of this legislation are not yet well understood. In this section, we briefly describe a few of the key issues in which outcomes in other states are informative and then describe some of the initial federal health reform implications Vermont will need to address.

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State Strategies to Control Costs

As described in the Sustainability section of this report, without cost containment measures, expanding access to insurance will not be financially sustainable for Vermont. The HCAA has several cost-saving measures intended to keep the program sustainable, including subsidizing enrollment in employer-based coverage (for those eligible for VHAP or Catamount Health subsidies) and containing costs through prevention efforts and chronic care management.

In states that have previously used similar ESI premium assistance models (e.g., Maine, Rhode Island, Oregon, and New Jersey), enrollment has often been low. Low enrollment has been attributed to limited availability of employer-based coverage at small firms^{18, 19} and high cost sharing for low-income beneficiaries.²⁰

Another key measure for cost containment in Vermont is the Blueprint medical home program. Blueprint for Health programs are expected to control escalating health care costs through community centered care teams, development of self-management tools for patients, improved health information systems, and coordinated approaches by health system organizations. However, the outcomes of these efforts on premium and claims costs to the State are not expected to be achieved until several years after implementation.

Vermont's focus on comprehensive health plan offerings and on promoting prevention as a way to control costs differs from the approach taken in Massachusetts. The Massachusetts health reform has had higher than anticipated costs and many people are enrolling in health plans that offer limited or inadequate coverage. Long-term viability of the Massachusetts reforms will require the State to address the cost issue and improve access to plans that are comprehensive.

Other states, including California, Maryland, Pennsylvania, and Wisconsin, are considering variations of Blueprint for Health reforms and similar strategies.²¹ Pennsylvania is already set in motion an initiative to promote quality and address issues around chronic care management. The State launched a chronic care initiative in May 2008 that began in southeastern Pennsylvania and will be rolled out statewide over a course of a year. This initiative has many features in common with Vermont's Blueprint for Health. In the coming years, these State based attempts to reform the health care delivery system in order to improve quality and control costs will be watched closely by federal health reform advocates and others to see the impact of these efforts.

¹⁸ Reschovsky, James D. and Hadley, Jack. *Employer Health Insurance Subsidies Unlikely to Enhance Coverage Significantly*. Center for Studying Health System Change Issue Brief 46. (2001).

¹⁹ Blumberg, Linda J. *Increasing Health Insurance Coverage of Workers in Small Firms: Challenges and Strategies*. Urban Institute Report (2007).

²⁰ Kaiser Commission on Medicaid and the Uninsured. *Serving Low-Income Families through Premium Assistance: A Look at Recent State Activity*. (2003).

²¹ Commonwealth Fund. *Vermont's Blueprint for Health*. March 27, 2000. Available at: <http://www.chcf.org/documents/EmployerInsuranceMandates.pdf>

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Eligibility and Enrollment Systems

Vermont may learn from States such as Louisiana, Massachusetts, and Wisconsin that implemented automatic enrollment strategies to increase enrollment and abate high administrative costs, especially since recent federal reform requires the implementation of a coordinated system for determining eligibility for Medicaid and subsidized coverage in the new health insurance exchanges (as described in the next section of this report).

Automatic enrollment works toward resolution of longstanding criticism of public benefit programs by tightening the application process, therefore promoting program integrity, and increasing enrollment of eligible individuals while lowering administrative costs by simplifying the application process. The enrollment of already eligible individuals also yields financial benefits for the state because if eligible people get sick it is likely that their providers will help them enroll into available health coverage at the State's expense. If they were already enrolled, early detection might have prevented some of these costs. In terms of sustainability, political vulnerability of a program can be lessened if low enrollment numbers that could "discredit" a program are avoided²².

Medicaid/ SCHIP renewals in Louisiana

In July 2001 Louisiana's Medicaid program changed its renewal procedures for children to ensure that children were not losing coverage because of errors or failure to complete paperwork. In May of 2009, the State began to use Express Lane Eligibility (ELE). ELE allows state Medicaid and CHIP agencies to rely on eligibility finding from other public programs such as SNAP (Supplemental Nutrition Assistance Program, formerly Food Stamps) or Head Start, and/or tax return data for to identify, enroll, and recertify children.

Using private grant funding for new technologies, an interagency agreement permits Louisiana's Department of Social Services (DSS) (which determines SNAP eligibility and is the designated Express Lane agency) to transfer data files electronically to the Department of Health and Hospitals (DHH), which administers Medicaid. DHH matches the SNAP files against Medicaid files to identify those children who are already enrolled. DHH then adds the remaining children to Medicaid eligibility and conducts an electronic match with Social Security Administration to verify citizenship of enrollees. Next, DHH sends parents Medicaid enrollment cards. At present, Louisiana views a child's first use of the Medicaid card as the family's "affirmative consent" to automatically enroll the child. In the future, Louisiana plans to expand its Express Lane agencies to include the SNAP system, as well as Child Care Assistance and WIC²³. As a result of the implementation of ELE, the percentage of children whose coverage was terminated in

²² Dorn, Stan (The Urban Institute). "Automatic Enrollment Strategies: Helping State Coverage Expansions Achieve Their Goals." Academy Health State Coverage Initiatives. Washington, D.C., Robert Wood Johnson Foundation, 2007. Available at: <http://www.statecoverage.org/files/Automatic%20Enrollment%20Strategies%20-%20Helping%20State%20Coverage%20Expansions%20Achieve%20Their%20Goals.pdf>. Accessed August 10, 2010.

²³ "Optimizing Medicaid Enrollment: Spotlight on Technology." The Kaiser Commission on Medicaid and the Uninsured. Menlo Park, CA: THE HENRY J. KAISER FAMILY FOUNDATION. Available at: <http://www.kff.org/medicaid/upload/8088.pdf>. Accessed August 10, 2010.

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Louisiana at renewal fell from 28 percent in June 2001 to 8 percent in April 2005²⁴. Challenges to implementing ELE include the fact that there are inconsistencies in data from the DSS and DHH, and these discrepancies can cause a match from the two lists to be overlooked.

Enrollment into Commonwealth Care in Massachusetts

For many years Massachusetts provided hospital care and certain outpatient services to the uninsured with the Uncompensated Care Pool (UCP). Now the Commonwealth Care (CommCare program) covers these uninsured residents of Massachusetts. At the program's inception, State officials automatically enrolled all individuals who previously used the UCP, and now people from 100-150%FPL are also automatically enrolled²⁵. On the CommCare website, Massachusetts residents can also check their eligibility for various State programs. Massachusetts' automatic enrollment system helped produce rapid and high take-up. The state currently receives 85 percent of enrollment applications through the website.²⁶

Wisconsin BadgerCare Plus

Wisconsin's BadgerCare Plus program, implemented in 2007, merged the state's three Medicaid programs for children, parents, and pregnant women into one comprehensive health coverage program. It also expanded eligibility to provide near-universal coverage for children and greater coverage for parents and childless adults. High demand for coverage and severe budget crises in Wisconsin has limited the success of BadgerCare Plus because several potential enrollees are now on waiting lists for the program. Despite this, Vermont can look to Wisconsin, as an example of how to simplify eligibility and enrollment processes.

The state worked to facilitate and simplify enrollment and renewal in BadgerCare Plus by partnering with community-based organizations and health care providers to identify and enroll eligible children and families. Organizations can automatically enroll children if their family income is less than 250% FPL and pregnant women if their family income is below 300% FPL. The enrollment process is further simplified because of the creation of a centralized and paperless application system. This system is fully integrated with an online tool, ACCESS, which allows individuals and families to determine their eligibility for public programs, apply for benefits, and check their application status. State residents

²⁴ Dorn, Stan (The Urban Institute). "Automatic Enrollment Strategies: Helping State Coverage Expansions Achieve Their Goals." Academy Health State Coverage Initiatives. Washington, D.C., Robert Wood Johnson Foundation, 2007. Available at:

<http://www.statecoverage.org/files/Automatic%20Enrollment%20Strategies%20%20Helping%20State%20Coverage%20Expansions%20Achieve%20Their%20Goals.pdf> Accessed August 10, 2010.

²⁵ IBID

²⁶ Volk, Gwyn and Jacobs, Anne. "Implementing State Health Reform: Lessons for Policymakers." Robert Wood Johnson State Coverage Initiatives. Princeton, N.J.: RWJ, 2010.

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are able to apply for health coverage electronically and the system simultaneously verifies the applicant's income and lack of access to employer coverage²⁷.

2010 Federal Health Reform

The two pieces of legislation - the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 - that comprise the federal health care reform efforts of 2010 (hereafter referred to collectively as PPACA) will undoubtedly have a profound effect on Vermont and its public and private health insurance markets. The PPACA calls for critical insurance and payment reforms that will necessitate substantial collective action between federal, state, and local stakeholders. State regulators in particular have been tasked with implementing some of the most integral provisions contained in the PPACA.

In many ways, the PPACA is a reflection of Vermont's history of innovative reform efforts, particularly in how both reform efforts utilize a hybrid of public and private insurance markets to significantly expand coverage. As a national leader in state health reform, Vermont is well-poised to use the impetus provided by the PPACA to further the goal of universal coverage. Already the Vermont legislature has passed legislation in support of a committee that will be tasked with exploring options for how Vermont can expand reform efforts using the PPACA. Vermont's challenge going forward will be, as asked by State Senator James Leddy, "Can the law that was passed by Congress be implemented in a way that coordinates and integrates with Vermont's effort or do we have to wait for the federal law to catch up to where we are?"²⁸.

While the PPACA will have short- and long-term effects on the provision of health insurance, it can be certain that some PPACA provisions will affect Vermont more than others. Recent discussions with Vermont stakeholders have focused in particular on three immediate challenges that will require significant planning and resources in order to effectively complement Vermont's own efforts at health reform:

- Expanding and reconfiguring eligibility standards for Medicaid
- The state mandate to create high-risk insurance pools
- Expanding and maintaining the state- and local-level administrative support systems that will be required for implementing federal health reform

Medicaid Expansion

Medicaid will play a key role in federal health reform. Significant federal funding in support of Medicaid expansion has been allocated to states in exchange for comparatively small increases in matching state funding. By 2014, Medicaid eligibility will be expanded to all qualified individuals under the age of 65 with income up to 133% of the FPL. Nationally, the CBO estimates that Medicaid rolls will expand by 16 million people

²⁷ "Wisconsin's BadgerCare Plus Program: Moving Forward on Health Reform Amid a Recession." Kaiser Commission on Medicaid and the Uninsured. Menlo Park, CA: THE HENRY J. KAISER FAMILY FOUNDATION. Available at <http://www.kff.org/medicaid/upload/8078.pdf>. Accessed August 10, 2010.

²⁸ Porter, Louis. "Hogan, Leddy named to health reform panel." Times Argus. June 14, 2010

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from a baseline of 35 million²⁹. Federal funding will be provided to pay for all of the newly-eligible adults from 2014 to 2016 through the use of enhanced federal matching for newly eligible Medicaid enrollees. This will be phased out in subsequent years and states will have to assume a greater share of federal funding for the newly-eligible individuals³⁰

As Vermont already covers childless adults up to 185% of the FPL using federal and state matched dollars through its Section 1115 Global Commitment waiver, it will not receive the enhanced 100% federal matching rate that states with less generous Medicaid coverage will receive for new eligibles. For the seven “expansion” states like Vermont that have already adjusted eligibility standards to include childless adults with incomes of up to 133% FPL, the federal government will provide a phased-in increase in federal matching dollars over time. This gap will continue to close until 2019, when all states will receive the same enhanced federal match for childless adults up to 133% FPL.³¹ States have the option to expand Medicaid eligibility to childless adults as early as April 1, 2010 but will not receive an enhanced federal match rate until 2014. Despite the inequities in federal matching funds in the short term for states like Vermont with relatively generous Medicaid coverage, early analyses of reform impacts suggest that even these states will benefit from significant savings generated by the PPACA.³²

State rules for Medicaid eligibility will also become much more standardized through: 1) use of the Modified Adjusted Gross Income (MAGI) standard for Medicaid eligibility; 2) eliminating any sort of asset test; and 3) simplification of enrollment procedures into Medicaid. These eligibility provisions will likely affect Vermont to varying degrees. For example, when determining eligibility, state Medicaid and CHIP will usually allow applicants to deduct certain expenses that help them claim eligibility for subsidized insurance. While the MAGI standard will be much simpler to use, it may result in pushing adults out of Green Mountain Care plans (children are prohibited from losing insurance coverage due to the application of the MAGI standard) and into other subsidized insurance plans sold on the state Exchange. These plans may be less generous in terms of benefits than those provided by Medicaid.³³ In terms of asset testing,

²⁹ Holohan, Dan and Dorn, Stan. What is the Impact of the Patient Protection and Affordable Care Act (PPACA) on the States? Washington, D.C.: Robert Wood Johnson Urban Institute, 2010.

³⁰ Holohan, John and Irene Headen (Urban Institute). "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL". Kaiser Commission Medicaid on Medicaid and the Uninsured. Menlo Park, CA: THE HENRY J. KAISER FAMILY FOUNDATION Available at <http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf>

³¹ Dorn, Stan (Urban Institute). "State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals." Academy Health State Coverage Initiatives. Washington, D.C., Robert Wood Johnson Foundation, 2010. Available at: http://www.statecoverage.org/files/SCI_Dorn_Report_2010_Final_updated_8.5.10.pdf. Accessed August 10, 2010

³² Holohan, Dan and Dorn, Stan. What is the Impact of the Patient Protection and Affordable Care Act (PPACA) on the States. Washington, D.C.: Robert Wood Johnson Urban Institute, 2010.

³³ Bernstein, William, Patricia Boozing, Paul Campbell, et al (California HealthCare Foundation). "Implementing National Health Reform in California: Changes to Public and Private Insurance". June 2010

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Vermont has mostly phased out the use of asset testing in determining Medicaid eligibility already.

The third provision requiring the simplification of enrollment procedures into Medicaid will require:

- A less complicated application process for not only Medicaid, but other forms of federally-subsidized insurance, including those sold on the state Exchanges.
- The creation of a web-based portal that will allow Vermonters to apply to, enroll in, or renew enrollment in Medicaid.
- Conduct efforts to increase enrollment among communities of vulnerable populations, including children, homeless youth, pregnant women, racial and ethnic minorities, rural households, etc.³⁴

As of August 2010, HHS has not promulgated a clear regulatory framework that will guide many of these critical changes to the enrollment procedures for federally subsidized insurance. However, it is expected that HHS will develop a single application form that can be used for all three need-based health insurance programs, Medicaid, CHIP, and subsidies in the Exchanges. States will be encouraged to use these forms, although they are by no means required.³⁵

The overarching application process will require significant interaction between Medicaid, the Exchanges, and external sources of data in determining eligibility. This will require data-matching systems that will allow all health agencies to exchange information from the application form and determine appropriate eligibility for Medicaid, the Exchanges, or some other form of subsidized insurance³⁶. At present, it appears States will bear the majority of costs for these required eligibility and enrollment upgrades.

High Risk Pools

The PPACA requires that every state implement a temporary high risk insurance pool program for residents who are denied coverage due to illness or injury; to that end, HHS has allocated \$5 billion for states to draw upon in support of the program, referred to as the Pre-existing Condition Insurance Plan (PCIP). These high risk pools are meant to last until each state has established their health insurance Exchanges in 2014³⁷. Each state has the option of contracting with HHS and implementing the PCIP itself, or allowing HHS to implement PCIP on its behalf. In order to be eligible for insurance coverage

³⁴ IBID

³⁵ Dorn, Stan (Urban Institute). "State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals. Academy Health State Coverage Initiatives. Washington, D.C., Robert Wood Johnson Foundation, 2010. Available at: http://www.statecoverage.org/files/SCI_Dorn_Report_2010_Final_updated_8.5.10.pdf. Accessed August 10, 2010.

³⁶ IBID

³⁷ Government Employees Health Association. "Pre-Existing Condition Insurance Plan." 2010 PCIP Brochure. July 2010. Available at <http://www.pciplan.com/forms/pdfs/brochure.pdf>

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under PCIP, individuals must be uninsured for 6 months and must have a preexisting condition³⁸.

Vermont is one of five states that already have guaranteed issue of insurance, along with Maine, Massachusetts, New York, and New Jersey. Additionally, all five states also require the use of community rating, which prevents insurance companies from charging higher rates for individuals due to poor health, gender, or other reasons³⁹. These states must contend with how best to create the high risk pool for the benefit of their constituents – and still lay claim to their allocated share of PCIP funding - despite technically lacking individuals who have been denied insurance due to preconditions.

Like 27 other states and the District of Columbia, Vermont originally opted to contract with the federal government to implement PCIP as a state program. Vermont initially wanted to use its share of the allocated funds (\$8 million) to expand coverage to VHAP and Catamount. State officials proposed shortening the required amount of time individuals had to be uninsured before qualifying for Catamount to 6 months, as well as eliminating all temporary exclusions. This plan was unfortunately rejected by federal officials, upon which Vermont policymakers proposed setting up a parallel insurance program similar to Catamount, but with the same features as their initial high risk pool proposal to HHS (6 month wait time; no temporary exclusions). This proposal was also not approved, and, ultimately, State officials decided not to create a separate high risk pool for Vermont but to refer people to the federal PCIP.

Expansion of State Administrative Operations

A commonly cited concern of Vermont legislators and policymakers is the extensive scaling up of state and local level administrative and support systems that will be required to fulfill PPACA requirements. Expanding Medicaid rolls, establishing the health insurance Exchanges and implementing the new health insurance mandates all have set deadlines and will require considerable effort from state agencies. Federal funding in support of the additional administration costs will cover about half of the associated increased spending; states will have to cover the remaining expenses⁴⁰. It is hoped that state savings associated with the PPACA will help defray some of these costs; whether these savings materialize will largely determine how well the new federal law is aligned with opportunities in Vermont.

³⁸ "PPACA and High-Risk Insurance Pools." Letter to Senator Michael Enzi. 21 June 2010. MS. Congressional Budget Office, Washington D.C. Available at http://www.cbo.gov/ftpdocs/115xx/doc11572/06-21-High-Risk_Insurance_Pools.pdf

³⁹ Kliff, Sarah. "State Rules Clash with Health Pools". Politico. Washington DC. July 20, 2010. Available at <http://dyn.politico.com/printstory.cfm?uuid=ECAB74D4-18FE-70B2-A85372A2B1FE71FE>

⁴⁰ Holohan, Dan and Dorn, Stan. What is the Impact of the Patient Protection and Affordable Care Act (PPACA) on the States Washington, D.C.: Robert Wood Johnson Urban Institute, 2010.

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IV. RESEARCH DESIGN

OVERVIEW

This evaluation uses a mixed method approach to evaluating Vermont’s 2006 HCAA.

- Interviews and focus groups with key stakeholders are used to clarify the historical context, policies, and practices involved with implementation and to gain insight around lessons learned that might be helpful as other states consider implementing health care reform.
- Primary and secondary data sets are used to assess the impact of the health care reforms on enrollment into new programs, public and private coverage rates, premiums and other out-of-pocket costs, access to care, program administrative costs, and related measures.

EVALUATION GRID

Table 3 presents the research questions for this evaluation, the data sources planned to address these questions, and the associated analyses.

Table 3: Evaluation Questions and Data Sources

Dimension	Questions	Data	Analyses
Process Evaluation	<p>To what extent have the goals, objectives, and outcomes of the legislation been met?</p> <p>What are the lessons learned during implementation?</p> <p>What are expected future directions in Vermont’s health care reform efforts?</p>	<p>Stakeholder interviews</p> <p>Publications and Historical Documents</p>	<ul style="list-style-type: none"> • Summaries of stakeholder interviews • Analysis of content for key themes and lessons learned
Affordability of Health Insurance and Enrollment	<p>Do the trends in health insurance coverage for Vermonters indicate an increase in public coverage?</p> <p>Are observed increases in public coverage due to increased eligibility or increased take-up rates among already eligible residents?</p> <p>How do Vermont’s trends compare to the region (New England) in insurance coverage over this same time period?</p> <p>To what extent is new coverage drawn from the pool of people who would</p>	<p>VT Household Health Insurance Survey (2005, 2008, 2009)</p> <p>CPS Insurance Coverage Estimates (2005, 2006, 2008, 2009)</p> <p>Administrative data on enrollment (Nov 07 – June 10)</p>	<ul style="list-style-type: none"> • Change in enrollment due to new initiatives (compared to national/regional trends) • Number of Vermonters that would have been eligible for new insurance programs in 2005 vs. number actually eligible in 2008/9 • Change in characteristics that predict resident propensity for insurance enrollment over time • Changes in uninsurance rates and private insurance rates over time (compared to national/regional trends) • Correlations between enrollment and population characteristics • Impact of specific program features in enrollment of specific

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	<p>otherwise be privately insured (crowd out)?</p> <p>Are the insurance plans affordable as measured by enrollment of the uninsured across demographic, socioeconomic, and geographic groupings?</p>		demographic groups
	<p>What is the impact of health reform on employer insurance coverage decisions (offer rate, benefit design, deductibles, and premium contribution) and risk of migration from commercial coverage to CH/VHAP?</p>	<p>Medical Expenditure Panel Survey MEPS (2006, 2008, 2009)</p>	<ul style="list-style-type: none"> • Changes in employer offer rate, benefits offered in plans, deductibles, uptake rate by employees, and employer contribution to premiums over time • Comparison with national and regional trends in employee benefits
	<p>How have the health reforms impacted premiums and out-of-pocket costs?</p>	<p>VT Household Health Insurance Survey (2005, 2008, 2009)</p> <p>MEPS (2006, 2008, 2009)</p>	<ul style="list-style-type: none"> • Trends in ability to afford needed care • Trends in out of pocket costs • Comparison of characteristics of plans offered in Vermont to national plans
Access to Care	<p>What effect do the policies have on the sustainability of community health centers with cost-based reimbursement and enhanced funds available for sliding fee scales for the uninsured?</p>	<p>DOH (changes in the number of FQHC look-alikes and use of sliding fee scales)</p> <p>OVHA Medicaid data on rate changes and utilization</p> <p>HRSA Uniform Data Set (UDS) data on VT FQHC payor mix (2006, 2007, 2008)</p>	<ul style="list-style-type: none"> • Trends in the number of FQHC look-alikes • Trends in the availability and level of sliding fee scales • Trends in Medicaid rates • Trends in Medicaid utilization
	<p>What effect do the policies have on the size of the population with a usual source of care?</p>	<p>VT Household Health Insurance Survey (2005, 2008, 2009)</p>	<ul style="list-style-type: none"> • Trends in number and characteristics of population without a usual source of care • Trends in reported barriers to care
	<p>What effect do the policies have on ER use by patients diagnosed with ambulatory care sensitive conditions?</p>	<p>ER use data (BISCHA) (2006, 2007, 2008)</p>	<ul style="list-style-type: none"> • Trends in ER use among patients with ambulatory care sensitive conditions
Sustainability	<p>How viable are the funding sources over time?</p>	<p>Program expenditure data (BISCHA)</p>	<ul style="list-style-type: none"> • Revenue projections from each source • Expenditure projections for each program
	<p>Are expenditures likely to exceed revenues over time?</p>	<p>Revenue data (VT)</p> <p>Expenditure and claims data (OVHA)</p>	

Note: Analyses planned to address access to primary care were not conducted due to lack of reliable data as described in Access to Primary Healthcare section below

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RESEARCH DESIGN, DATA, & METHODS

Process Evaluation

In order to understand the processes by which Vermont's health care reforms were enacted and implemented, we conducted a series of key informant interviews in late 2008/early 2009 and again in early 2010. We interviewed a variety of stakeholders, including representatives from Vermont's legislature, representatives in the Douglas administration who are responsible for implementing the new programs, insurers, provider organizations, and non-profits involved in advocacy and/or implementation. A list of these key informants is included in Appendix 1. Our interviews covered a wide range of topics from the context for reform before the legislation was passed, to perceptions of the success of implementation, to lessons learned so far, and future directions. Many similar themes were described by different informants.

With help from Dr. Susan Besio, Commissioner of the Office of Vermont Health Access, we generated a list of key stakeholders. Stakeholders were contacted by email to explain the study, and, if needed, a follow-up phone call was made to arrange a time to meet with each individual. In the first round of interviews, researchers conducted 3 days of in-person interviews in Vermont in December 2008. Because some of our key informants were not available during the time that we were in Vermont, we also conducted interviews by phone in February and March 2009. A total of 20 interviews were completed. For the second round of interviews, several of the original interviewees were re-interviewed in order to get an update and assess interim changes in Catamount implementation, legislation, or other processes. Additionally, several new stakeholders representing sectors not included in the first round were contacted in order to increase the representativeness of respondent viewpoints. All of the second round interviews were conducted by phone after an initial e-mail invite. The complete list of interviewees by year is contained in Appendix 1.

The interview questions were focused around key factors that contributed to passage of HCAA, assessment of the success of implementation to date, and predictions and concerns regarding the future of both the Catamount Health Plan, Blueprint for Health and any other health reform related programs. Appendix 2 includes the general questions used in the interviews. Although these questions formed the framework for interviews, the interviews were generally free-flowing (e.g., informants often brought up topics that were not initially part of the framework, and interviewers often posed new questions that arose from the information the informants were presenting).

Detailed notes were taken during the interviews, and, with the permission of informants, interviews were recorded. After the interviews were completed, the notes were transcribed, and where necessary, the recordings were used to clarify information. Using the notes and historical documents, we were able to re-construct the history of the reforms, background information, details around implementation, and perceptions around successes, failures, lessons learned, and the future of health care reform in Vermont.

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Affordability of Health Insurance and Enrollment

To answer the research question - *How affordable are Vermont's insurance plans across demographic and socioeconomic groupings?* - we use data from several sources including: OVHA monthly administrative data on enrollment into Catamount Health (CH) and other publicly subsidized programs, VHHIS data showing actual health coverage of Vermonters in 2005 compared to 2008/2009, and CPS health coverage data for New England and the United States as comparisons.

The first question we investigate is whether the insurance plans are affordable as measured by enrollment of the uninsured into Catamount across demographic and socioeconomic groupings. To address this question, trends in enrollment by income, age, and other demographic factors were analyzed to examine patterns in enrollment. Additionally, baseline data on insurance coverage and related factors (age, income, employment, health status, etc) from the 2005 VHHIS are compared to results from 2008 and 2009 surveys to explore trends in health insurance coverage since implementation of the health reforms, with a particular focus on changes in public insurance coverage. The Current Population Survey (CPS) is used for comparison health coverage trend data that will allow us to parse out the proportion of the observed change attributable to initiatives in Vermont, rather than to national or regional trends. We assessed impacts of coverage reform across broad demographic and socioeconomic groups.⁴¹

The second question to be addressed in assessing affordability is whether any observed increases in public coverage are due to increased eligibility (e.g. new reform programs like Catamount) or increased take-up rates among already eligible residents to pre-existing Medicaid programs. The former would indicate affordability of new programs for the newly eligible, while the latter would indicate increased outreach and marketing efforts resulted in increasing coverage for those already eligible for assistance prior to the reforms. To examine the impact of each of these factors, we use VHHIS data to estimate the segment of the Vermont population in 2008 and 2009 who were eligible for each of the new programs and compare our findings to the number of residents who would have been eligible for the programs in 2005, had they existed at the time. We explore the reasons for changes in the eligible population and will identify subgroups of the 2005 eligible population who subsequently became insured through the new programs or through other avenues of coverage; identify characteristics that predict resident propensity to be covered by private or public insurance or to be uninsured in 2005 and how these characteristics and propensities changed over time; and conduct shift-share decompositions to see how changes in characteristics and propensities affected coverage.

A third question related to affordability addresses the impact of health reform on employer insurance coverage decisions (offer rate, benefit design, deductibles, and premium contribution) and risk of migration from commercial coverage to CH/VHAP.

⁴¹ We use the 2005-2009 within state comparison (difference) and the 2005-2009 cross-state comparison (difference-in-differences) to assess the impact of coverage reform across broad groups defined by income, age, and employment. We also use multivariate and propensity score methodologies to construct groups defined across multiple dimensions in the 2005, 2008, and 2009 surveys and in the comparison state surveys and compare outcomes across these multidimensional groups.

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As part of our study, we sought to use data from the Vermont Fringe Benefit Survey to examine the impact of health reform on employer insurance coverage decisions in Vermont, including offer rate, benefit design, deductibles, and premium contribution. We also planned to look at benefit design in Vermont plans in comparison to national plans. One barrier to our study of these issues has been the availability of data collected through the Vermont Fringe Benefit Survey. This survey was administered in 2005 and 2007, which would both serve as baseline years for our analysis, but the full dataset for 2007 has not yet been released. In addition, we had expected the survey to be conducted again in 2009, but the State did not collect data in 2009 due to financial constraints.

Because of these issues with data from the Vermont Fringe Benefit Survey – and because categories for the Vermont Fringe Benefit Survey are not fully comparable to other national surveys – we analyzed data from the 2006, 2008, and 2009 AHRQ Medical Expenditure Panel Survey (MEPS), which includes both national and state-specific data on health insurance to provide insight into health insurance coverage in Vermont in comparison to the nation. The 2006 MEPS data serves as a baseline for Vermont, as the survey was conducted prior to the implementation of Vermont’s HCAA, and 2008 and 2009 serve as the post reform comparison (2007 MEPS data was not available).

MEPS data is presented for Vermont and for the nation. For a regional comparison, we also have calculated averages of the six New England states (Connecticut, Rhode Island, Massachusetts, Maine, New Hampshire, and Vermont). The New England average is not weighted by number of firms or state population; each state is equally weighted. The MEPS data gives us a glimpse of how employment-based insurance in Vermont compared to other states in the region prior to the HCAA. This helps us understand the unique challenges faced by Vermont with respect to employment-based insurance and whether the HCAA is helping the state to meet these challenges.

Finally, an important consideration is the extent to which new coverage is drawn from the pool of people who would otherwise be privately insured (crowd-out). To estimate the extent of crowd-out, we examine both changes in un-insurance rates over time and compared to regional trends and also examine changes in private insurance coverage compared to the region. If private insurance in Vermont declines more rapidly than elsewhere, this difference may be partly attributable to crowd-out.

Access to Primary Healthcare

We had planned to address the question of how health reform impacted access to care in a more comprehensive way than we ultimately were able to. There were several issues that impeded this analysis. First, we had planned to study community health center data to measure changes in payor mix over time at these federally funded clinics, since a major expansion of the health center program in Vermont (at least one in every county was the goal) was part of the 2006 health reform legislation. However, we learned from the Bi-State Primary Care Association that the Uniform Data System (UDS) is still a work in progress for most of the new health centers and that the payor mix data was likely unreliable for some of the centers.

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Second, we tried to determine whether it would be possible to analyze changes in hospital discharge data for ambulatory care sensitive conditions in regions where there had been health centers opened in the years since reform as a proxy for access changes. However, we learned from Bi-State that almost all of these new health centers were actually existing primary care practices that received or are applying for federal qualification and 330 grant status, rather than new access points. This would greatly diminish the likelihood of finding any significant changes in hospital or ER admissions since most of these practices have an existing panel of patients in their region when they received FQHC designation. It is unlikely that many will recruit new patients to the practice. We were able to use VHHIS data to examine reported access to care, use of ER, and barriers to care, but ultimately these analyses were inconclusive and did not add to our findings. We had hoped for a more in-depth look at this issue since access to care is the ultimate goal of most coverage expansions.

Sustainability of Health Reform Programs

For state health reform to be successful, especially when health reform involves a state sponsored health insurance plan, financial policies must be in place to ensure program fiscal sustainability into the future. Vermont health reform legislation placed an early focus on sustainable funding sources for both new and expanded coverage plans. As mentioned in an earlier section, the funding sources included an increase in tobacco taxes, the federal Medicaid match (waiver), and the assessment on employers not offering approved health insurance.

Vermont policies to ensure fiscal sustainability also included the use of Employer Sponsored Insurance (ESI) premium assistance to reduce enrollment in CH or VHAP for persons eligible for CH or VHAP who also have access to an approved employee based insurance plan. By directing all eligible persons now uninsured or insured through the Medicaid VHAP program to an approved ESI program, the state also expects savings in VHAP program claims and lower costs for CH premium assistance programs. In addition, Vermont lawmakers agreed to use state funds to implement the premium assistance programs between 200% and 300% FPL, since CMS only agreed to include federal match for those up to 200% in Vermont's original 1115 waiver, with the expectation that CMS policy will change within the next few years. This change only occurred recently (in December 2009), so for most of the time under study, premiums for Catamount enrollees between 200 and 300% of the FPL were subsidized by State funds only, with no federal match.

At the core, evaluating fiscal sustainability requires building the equivalent of a financial profit and loss statement for the program. To accomplish this, we obtained information from Vermont on the aggregate (and individual) value of the funding available from revenue sources to cover major components of health reform--in particular, the expanded insurance coverage programs. These included the funding sources described above and represent program revenue streams. Costs for each program component were calculated from information provided by the state. In addition to direct program costs, also included were administrative and marketing expenditures. Fiscal data on program costs were then compared to the revenue projections from the identified sources. On the expenditure side,

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we initially expected to obtain data on both premiums and program claims. However, we later learned that the State only reports expenditure information for CH and ESI program insurance premiums paid for by state and federal sources and not claims costs.

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V. PROCESS EVALUATION

HOW HAS IMPLEMENTATION COMPARED TO WHAT WAS EXPECTED?

This section of the report presents information from key informant interviews. Interview data is complemented by information from articles and papers written about the reforms.

Outreach

The 2005 Vermont Household Health Information Survey (VHHIS) showed that up to 50% of uninsured Vermonters were eligible for existing state Medicaid programs. These individuals, who had not enrolled in existing programs, were not expected to be helped by new programs or by expanding programs to those with higher incomes. Rather, covering these uninsured individuals would require the state to improve its efforts to enroll eligible people by informing them of programs and reducing the barriers to enrollment. Because of these findings, outreach efforts were included as part of the implementation of the reforms.

The goal of outreach efforts was to reach not only those who might want to enroll in the new Catamount Health plan but also those eligible for existing Medicaid programs such as VHAP. In addition, part of the outreach campaign emphasized the need for insurance to the general public.

One of the first milestones in outreach work was the rebranding of all of the State-funded programs (including Catamount) to Green Mountain Care. This name and new logo was developed as a result of focus group input gathered by GMMB, a strategic communications firm, and Lake Research Partners, a public opinion and political strategy research firm. The rebranding was part of an attempt to de-stigmatize and simplify the administration of publicly funded health care programs in Vermont.

The GMMB/Lake Research Partner focus groups provided information on the types of messages about insurance that were effective for Vermont residents. Using this information, a series of television and print ads were developed. On November 1, 2007, the statewide outreach campaign for Catamount officially began. The television and print ads initially were run for a 6 week period.

The ads guided people to a Green Mountain Care website (www.greenmountaincare.org), where they could find more information on the various health insurance programs. The website guided potential applicants through the application process. It also included a screening tool whereby potential applicants to any of the programs could determine which was the appropriate program to apply for based on a series of simple questions about income, household size, and existing coverage.

Although outreach was an important part of the reforms, the state only funded one position for Outreach, the Director of Catamount Outreach & Enrollment. However, a

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collaborative effort among various informants ensured that outreach efforts extended beyond the reach of state resources. An Outreach and Enrollment Steering Committee was formed with representation from various divisions within the State government, insurance providers, Vermont Campaign for Health Care Security, AARP, Bi-State Primary Care Association, provider associations, the business community and others. These organizations were able to leverage their own resources to reach their constituencies and broaden the outreach efforts, despite limited state funding.

Another important facet of the outreach efforts was the development of a training curriculum that was used to train over 2000 health care providers, outreach workers, human resource professionals and others who work with people on eligibility and enrollment for health care. There were also targeted outreach efforts, particularly for the 18-24 year old age group. This group was targeted through sponsoring of concerts, e-mails to college seniors, letters to faculty and parents and the hiring of young Green Mountain Care ambassadors to do outreach within their communities. Other examples of targeted campaigns included the marketing of the amnesty for pre-existing conditions from June to November 2008, targeted efforts to home health and mental health direct care workers via their payroll systems, and the creation of Rapid Response Teams to deploy to companies conducting layoffs in an effort to ensure they knew about their potential eligibility for new and/or existing state programs.

A survey conducted in January 2008 by Lake Research Partners to gauge the success of early outreach efforts found that nearly half of Vermonters had heard of Green Mountain Care and almost 1 in 5 had attempted some sort of action as a result of the media campaign, ranging from going to the website to telling a friend about the programs. This survey also found that 88% of Vermonters indicated positive associations with state-sponsored health coverage.⁴²

Enrollment

As mentioned earlier, during legislative discussions prior to passage of the reform, two independent estimates of projected enrollment were developed. Although outreach for Green Mountain Care was robust, enrollment for both Catamount and Employer Sponsored Insurance with Premium Assistance did not reach those projections in the first year of the program. As a result, in July 2008, actual enrollment data from the first year of the program were used to develop new, revised projections of enrollment for future years. So far, the revised projections for enrollment have aligned with actual enrollment since the revision. However, our person-level enrollment analysis also found that churning, or enrollment and subsequent disenrollment from and between State programs, is occurring among a large proportion of these enrollees. A more detailed analysis of enrollment figures is included in the next chapter of this report. However, in interviews, we asked informants whether enrollment met their expectations, why enrollment was lower than those initial projections, and what they thought might be driving the churning finding.

⁴² "Awareness of Green Mountain Care: Results from a Statewide Survey of Vermonters", Lake Research Partners, presented February 6, 2008.

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Although the original enrollment projections used available data and statistical modeling, many informants expressed that it would have been impossible to accurately predict enrollment given the unknowns involved in these calculations. Most interviewees also expressed satisfaction with existing enrollment levels.

Many of the individuals we interviewed felt that enrollment in the Green Mountain Care programs was adequate, even though it was lower than initial projections. However, some informants felt that enrollment was inadequate, either because it was lower than projected or because they had heard from the Vermonters they represent that there were barriers to enrollment.

The affordability of the plan, particularly for those individuals who do not qualify for premium assistance, was one barrier cited by informants. Enrollment in Catamount Health costs over \$400 a month for individuals, and, thus, it may not be affordable for those with family incomes just above 300% FPL, who do not qualify for premium assistance but have limited disposable income. Enrollment among those who do not qualify for premium assistance was limited, perhaps, in part, as a result of the cost of the plan. Additionally, some of the key informants felt that even Vermonters who qualify for premium assistance find their monthly premium share too expensive. In particular, those who are young, healthy and free of disease may perceive the plan to be unaffordable. The fact that the majority of those who signed up for Catamount receive some level of premium assistance indicates that it may not be affordable without this subsidy and, in some cases, may not be *perceived* as affordable even with subsidies. Enrollee premiums were increased in 2010 for those above 200% of the FPL as a result of rate filing increases from both MVP and BCBS (rates for those below 200% were protected by ARRA and PPACA Maintenance of Effort provisions).

A second reported barrier to enrollment is the 12-month waiting period for coverage. Although several events pre-empt this waiting period (e.g., being laid off or becoming ineligible for parental coverage due to age), many individuals would have to be uninsured for 12 months before qualifying for Catamount Health. For those who are self-employed – and, thus, cannot be laid off – or those who only have catastrophic insurance plans because they have not been able to afford comprehensive coverage (the underinsured⁴³), this waiting period is particularly problematic. Many are not willing to bear the risk of going without coverage for a year, even if their current coverage is much more expensive than Catamount Health or if it is inadequate.

The issue of the underinsured is of particular concern, and the legislature attempted to address this issue in 2008. Act 203 of 2008 allowed those with deductibles of \$10,000 or greater (single coverage) to sign up for Catamount without waiting for 12 months. Act 61 passed in 2009 further reduced the high deductible exemption to \$7500 and changed the rules for eligibility of self employed and small business owners in cases of businesses

⁴³ Although researchers, including the Commonwealth Fund and others, have recently been working to create a quantifiable, common definition of underinsurance, in this report we are using the term in a more general sense. It is a topic that arose frequently in our key informant interviews and was generally described as an inability to afford out of pocket health care costs among the insured.

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closing or bankruptcy. Although Acts 203 and 61 improved opportunities for the underinsured, some informants felt that the new provision was inadequate to address the concerns of the underinsured for several reasons including:

- There is likely a significant cohort of Vermonters who have insurance deductibles between \$1000 and \$7500. These individuals could be considered underinsured because they cannot access primary care and preventive services without substantial out of pocket cost. However, they originally did not qualify for the waiting period exemption.
- Those with a \$7500 or greater deductible in their existing coverage, while now exempt from the 12-month waiting period, are not eligible for Catamount premium assistance until one year from the date they sign up for a Catamount health plan. Purchasing Catamount at full premium price for one year may not be an option for many of these Vermonters.

Based on the small number of enrollees to the full price Catamount Health Plan, the removal of the 12-month waiting period for those with deductibles of \$10,000 or more does not appear to have made much of an impact. The Commission on Health Care Reform has been charged with addressing the complex issue of the under-insured, but to date no substantial progress has been made on this front.

Some who we interviewed in the first year after reform expressed a desire to change the 12-month waiting period to 6 months to address this barrier to enrollment. This change was included in 2009 legislation and received federal approval through an amendment to the Global Commitment Waiver. However, state budget constraints prevented this change from being implemented. It is unclear whether this change will be enacted in the future.

A final barrier to enrollment in both Catamount Health, the ESI premium assistance program (ESIA), and VHAP ESI is the enrollment process itself. There are several issues that complicate enrollment. They include the following:

- Although there is a common website for determining potential eligibility for programs, actual enrollment, until recently, required a multi-step process due to the need to dually sign up with the State for premium assistance via a contracted enrollment company, Maximus, and then to sign up for Catamount, ESIA, or VHAP ESI with a private insurance company. Recently, a change was made to create a one-step process for Catamount enrollment from the enrollee perspective, whereby the State works directly with the insurance companies and eliminates the second step.
- Additionally, those potentially eligible for ESIA must produce documentation about the coverage offered to them through their employer and must wait for the state to determine comparability and cost effectiveness of their employer's plan versus Catamount.
- The enrollment processes and methods were designed for low income, Medicaid populations and are now being used for private insurance product with a target

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audience above 200% FPL. Many enrollees were not used to being asked to produce income documentation for insurance purposes. Further, it was noted that the HCAA legislation mandated some language that increased the clumsiness of forms for the new programs.

The State of Vermont has been revising its eligibility process in order to provide final eligibility determination online and to streamline the current process, but it is not clear whether the funding will be available in upcoming budgets to accomplish this soon. The federal mandates for online enrollment and eligibility determination in the 2010 PPACA increase the urgency for Vermont to update these systems, but it is unclear at this point whether there will be adequate federal funding to augment these changes. In any case, the OVHA and legislature have done an impressive job of responding to identify shortcomings in the programs and making modifications to improve the eligibility and enrollment processes despite minimal funding specifically allocated for this purpose.

One other barrier to enrollment that should be noted affects ESIA. Employer sponsored insurance has to be comparable to Catamount for Vermonters to receive premium assistance through ESI. While many advocates report that this coverage determination is minimal (e.g. only need to provide both hospital and doctor visits and deductible less than or equal to \$500), some in the business community say that the standard is too high for most businesses in Vermont given their small size and the relatively low deductible by today's standards. The VHAP ESI program does not have as stringent comparability requirements because the state offers "wrap around benefits" and pays for care that VHAP would cover but the ESI program does not. Thus, comparability is less of an issue. However, enrollment still involves a multi-step process, and the applicant is responsible for gathering the required employer insurance documentation, if applicable.

As mentioned above, there are also indications that many who enroll in the Green Mountain Care programs drop coverage periodically and re-enroll later. In order to explore this finding, we asked key informants to reflect on the possible causes of this "churning." One cited factor is the renewal process itself. After 12 months on the program, a form is mailed to participants asking for updated income information and asking them to mail back the form. Advocates report that this process is cumbersome and confusing to many enrollees and that if the form is not returned in time, the policy may be cancelled requiring re-enrollment. This is another area that the State has identified to work on in the coming years. Many other States have struggled with these issues, and there are creative examples to emulate including using pre-populated forms or allowing people to renew by phone as described in a previous chapter.

Another potential cause of churning cited by key informants includes the cost of the program or affordability. Many expressed that it remains unclear whether those who drop off due to the cost of premiums truly can't afford this product or simply make choices to spend their money on other needs. Further, some suggested that the high quality of the Catamount product, and its associated cost, may not be the right vehicle for those who want to spend less on health care because they are relatively young and healthy. Lastly, it was suggested that many of the people eligible for services have less

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stable employment and income, and therefore, their eligibility for Catamount vs. VHAP vs. Medicaid changes from month to month. This factor was cited particularly in the context of the 2008/2009 recession which increased employment instability. However, despite these enrollment and re-enrollment challenges, most agree that actual enrollment has been successful and has led to more Vermonters with health insurance coverage, despite the current economic environment.

Federal Match

Another theme which emerged in our interviews regarding expectations for implementation of the health care reforms is the disappointment with the decision on the part of the Centers for Medicare and Medicaid Services (CMS) not to grant matching funds for Catamount eligibles between 200 and 300% of the FPL in the original Global Commitment Waiver. It was highly anticipated that CMS would allow federal matching up to 300% FPL based on Massachusetts securing this approval in its 1115 waiver for comprehensive health care reform. However, CMS only granted a match up to 200% FPL which meant that Vermont has had to contribute a greater amount of state resources to enact Catamount than was originally projected. The State received this approval under the new federal administration for federal matching for Catamount recipients up to 300% via a waiver amendment request that was submitted in 2009.

Ongoing Policy and Legislative Changes

One of the unique aspects of Vermont's health reform that was discussed by many informants is that its implementation is viewed as an ongoing experiment. As a result, various bills have been passed since the original enactment of Acts 190 and 191 to refine the programs and address early implementation issues. As described in an earlier section on the history of the legislation, several bills have been passed so far that modify and clarify the original HCAA health reforms. Some of the examples of these changes and their perceived implications are discussed here:

- Since CMS did not originally expand the federal matching within the Global Commitment Waiver up to 300% FPL, Vermont sought another way to increase federal matching funds and help pay for the program. The legislature set in place a \$400 "earned income disregard" for Catamount and Catamount ESIA applicants. Essentially, applicants between 200% and 300% of the FPL were able to subtract \$400 a month from their earned income when applying for the program. This moved many individuals into lower income categories for calculation of premium assistance and was specifically intended to move some applicants into the less than 200% FPL category, making these individuals therefore eligible for federal matching funds. It has been suggested, however, that this income disregard may also have had an unintended effect of pushing people from Catamount eligibility to VHAP or regular Medicaid although this has not been studied yet. This income disregard was paired with a small increase in Catamount premiums to offset any cost increases to the state incurred by making people eligible for higher levels of premium assistance.
- Another important example of amendments to the HCAA was the temporary amnesty of pre-existing condition exclusions in the original legislation that

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created the Catamount Health plans offered by Blue Cross Blue Shield and MVP. The Catamount health plans both include a pre-existing condition exclusion clause which allowed the insurance companies to not cover costs associated with pre-existing conditions for the 1st year of enrollment unless people had credible coverage within the past year without a 63 day gap in coverage. The amnesty provided that enrollees with pre-existing conditions who signed up for Catamount during the four month amnesty period would have costs associated with their conditions covered from that point forward. This amnesty expired on November 1, 2008, but likely provided an opportunity for older, sicker adults to have costs associated with pre-existing conditions covered immediately through Catamount and, therefore, may have increased enrollment among older adults.

- As discussed earlier, the HCAA were also amended to provide exemption from the 12 month waiting period for those with deductibles greater than \$10,000 for an individual (\$20,000 for a family) to address the underinsured. These limits have since been decreased to \$7500 for single coverage and \$15,000 for family coverage.
- There were also several amendments and additions to the Blueprint for Health efforts to address public health infrastructure including identifying core public health functions and developing multi-payer integrated medical home pilot projects.

Key informants expressed primarily positive reactions to the ongoing legislative work to refine the HCAA and described the overall health care reform efforts as an ongoing work in progress. With the wide-ranging health policy and insurance reforms mandated in the PPACA, it is expected that there will be additional changes to the reform efforts in the coming years.

Future Prospects and Challenges

Key informants generally expressed hopefulness about the future of Vermont's health care reforms but acknowledged that there were many unanswered questions at this point regarding the impact of federal health reform on states and whether states can maintain coverage expansion programs in a sustainable manner without substantial federal funding.

Regarding the financial prospects for the health reforms in Vermont, informants predicted future opportunities as well as challenges. All those interviewed agreed that the current Catamount program, given Vermont's budget realities, is not sustainable with existing revenue sources. The employer assessment included in the HCAA amounts to approximately \$1 a day for each full time equivalent (FTE) who is not covered by employer sponsored insurance. There has not been a great outcry from employers regarding this assessment to date. On the other hand, there is a question as to whether this assessment amount is adequate in terms of supporting the increased state costs of Catamount and other health reform programs and providing incentives for employers to provide insurance to their employees. Similarly, the increase to the cigarette tax, which is a dedicated revenue source for the state to apply to health reform programs, is expected by many to be a declining revenue source over the years due to ongoing efforts to

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decrease and prevent tobacco use. However, there was wide disagreement on whether the primary approach to sustainability should be to generate more revenue (e.g. new sugar tax) versus limiting costs to the program by increasing participant cost-sharing or limiting eligibility.

Improvements to the health care system expected to be achieved through the Blueprint for Health were cited as an opportunity for cost savings. These improvements, such as Medical home pilots, are intended to create a more cost-efficient health care system by preventing and managing chronic disease in the primary care setting to prevent the costly sequelae of disease that result in hospitalization and expensive treatment needs. Similarly, free immunizations for all Vermonters may decrease the prevalence of disease in the population and thereby decrease the overall health system costs. Several interviewees also indicated that the announcement of Medicare pilot participation in medical home reimbursement will free up state money currently being used to support Medicare patients in the Vermont medical home pilot. While informants perceived the Blueprint for Health as a promising initiative, most admitted that these types of cost savings typically take many years to be realized and cannot be counted on for near term financing of the costs to implement new programs.

Representatives from both hospitals and community health centers in Vermont report anecdotally that have not seen substantial changes to their uncompensated care costs or payer mix since the introduction of Catamount, despite the fact that the percentage of uninsured in Vermont appears to have decreased. This lack of effect on providers' bottom line is posited to be due to the shift among many of the privately insured from relatively comprehensive benefit plans to high deductible plans where the patient bears the costs for care up to the deductible amount. If people with these types of plans are unable to reimburse hospitals and clinics for their first \$1000 or \$2500 of care, this could increase uncompensated care burden and offset any increase in the insured population. This population with high deductibles, often termed the under-insured, will need to be addressed in future health reform if trends continue among employers towards these types of plans.

As mentioned previously, another big unknown regarding the sustainability of the health reform relates to the future of Catamount in the context of federal health reform. Some indicated that Vermont just needs to bridge its healthcare spending deficit until federal health reform is full enacted because Catamount can become a product in the new health insurance exchange and state subsidies could be federally subsidized instead. However, it is not clear at this time whether states like Vermont, that were early adopters of statewide comprehensive health reform, will benefit to the same degree from federal health reform as States that had less generous coverage options at the time of PPACA enactment.

Despite these lingering questions regarding future funding for the new programs, most agree that the HCAA has been a success and that many of the goals it set out to achieve are being realized. The number of uninsured has decreased in Vermont. The Health Information Technology Trust Fund has been put in place and there are plans to

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implement electronic medical records for independent primary care physicians throughout the state with this fund and also with the Medicaid and Medicare incentive funds available through the Federal High Tech Act of 2009. The Blueprint for Health pilots have been a success according to those involved, and these efforts are expected to continue and spread statewide in the coming years. So while the future remains an unknown in terms of federal health reform and revenue streams to fund coverage, the successes of the health reform to date are certain to spur on continuing efforts in Vermont to improve upon its current system and to work toward the goal of insuring 96% of Vermonters by 2010. In fact, the single payer (public) option remains on the table in Vermont, as evidenced by the fact that it was one of the 3 design options requested from consultants in legislation passed in 2010⁴⁴.

WHAT LESSONS WERE LEARNED DURING IMPLEMENTATION?

Key informants offered insight learned from implementation that may be helpful to Vermont as it moves forward with future reforms and implementation issues. These lessons may also be valuable to other states as they attempt health care reforms of their own.

Implementation of Health Reform is an Ongoing Process (or Devil's in the Details)

Key informants consistently described the implementation of health reforms in Vermont as a dynamic process, with ongoing changes and modifications to the programs. Even though passage of the 2006 HCAA involved a concerted effort on the part of many different stakeholders, the real work did not begin until implementation of the programs began. Implementation has been a complex undertaking as evidenced by the five reform bills enacted after the initial HCAA to address shortcomings and/or omissions from the initial bill. There also appear to be many differing opinions on issues around implementation (e.g., Is the public-private hybrid system working or would a fully state-run plan work better? Are the plans affordable? Is enrollment adequate?). The development of the initial consensus to pass health care reform was just a start.

Continuing to find viable solutions to various issues around implementation is an ongoing process and can be informed by preliminary results and the ability to address challenges as they arise. Even with the relatively small size of Vermont and its history of innovative health care reform, which creates an ideal breeding ground to experiment with different approaches to controlling health care costs and increasing access to care, implementation has been challenging. Other states would be prudent to build in to any future health reforms the ability to make mid-course modifications to programs as implementation unfolds.

⁴⁴ Act 128 (also know as S.88) of the 2010 Vermont legislative session calls for the state to enter into an agreement with a consultant to design 3 models for comprehensive reform of Vermont's health care system. Models include a single-payer system; development of a public option to compete with private insurers; and a third option, up to the consultant, to design a system to achieve the goals of Act 128. In June, 2010, the Health Care Reform Commission recommended and the Joint Fiscal Committee accepted a proposal by a team led by Professor William Hsiao of Harvard University. A legislative summary of S.88 / Act 128 can be found at: <http://www.leg.state.vt.us/docs/2010/Acts/ACT128sum.htm>

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Stakeholder Collaboration is Necessary

Another key lesson for state health care reform efforts which can be gleaned from Vermont's experience is the importance of collaboration. The collaborative spirit which led to passage of Vermont's health care reforms was no small feat. From the initial efforts of the Governor and of the Commission on Health Care Reform to reach out to the public through meetings and focus groups to the compromise between the legislature and Governor's office on the final passage of the HCAA, Vermont's story is a lesson in the importance of working collaboratively to achieve large scale health reform.

Many of the people we spoke to attributed this collaboration to the culture and size of the state of Vermont where it is relatively easy to identify and gather various stakeholders from differing backgrounds who may have worked together previously or know each others' families. However, another aspect which contributed to the ability to collaborate among groups and individuals with varying motives and incentives for being at the table was the idea that enacting some sort of health care reform was more important than any particular strategy or philosophy regarding the ideal health care reforms. Although not all stakeholders ascribed to this view, enough did to enable compromise to occur.

Collaboration continues to be a hallmark of the implementation process. Outreach efforts involve a Steering Committee representing various advocacy groups and administrative departments who work together to deliver the message about the new programs available to residents. The Blueprint for Health effort requires collaboration between private insurers, public and private providers, and state government. Similarly, the collaboration between the Office of Vermont Health Access and private insurers in order to implement Catamount and ESI programs is an ongoing and relatively successful process.

Federal Assistance Is Needed for Sustainability

The importance of collaboration between federal and state funders in implementing health care reform is also clearly evidenced in Vermont. Although Vermont used general fund dollars to offset the unrealized revenue that was anticipated from federal matching in the Global Commitment Waiver for those individuals between 200% and 300% of the federal poverty level (until matching to 300% FPL was approved in late 2009), it is widely acknowledged that this level of state funding was only sustainable in the short term. This necessity points to the crucial importance of federal and state collaboration in funding state health care reforms. States simply cannot afford to take on health care reform without significant federal participation in funding. Now that comprehensive federal health reform has been enacted, the role of federal funding participation in the many mandates of the PPACA will be an important issue to watch.

Making Eligibility and Enrollment Processes Easy is Key

The eligibility and enrollment processes for the various programs have also required ongoing attention and reworking. Although Vermont focused on this issue and set up a website for Green Mountain Care to integrate information on new and existing programs, this website only provided a screening tool to preliminarily assess eligibility for these programs. The actual enrollment process for Catamount initially involved application to

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the State for premium subsidies and a separate application through the private insurance company for actual coverage; recently these applications have been combined into one. This process could be even lengthier and more complicated for ESI applicants who are responsible for gathering information about their existing employer offered coverage in order to determine comparability with Catamount or VHAP program.

Many key informants expressed the opinion that the eligibility, enrollment and re-enrollment processes were cumbersome for consumers and would likely need to be simplified in order to reach targeted enrollment levels. This has been complicated by the reliance on old computer systems to collect new data. A recommendation for other states would be to pay specific attention to eligibility and enrollment processes from the beginning to increase the likelihood that consumers will be able to navigate the system and to facilitate collection and processing of information by the state.

Health System-Level Improvements are Needed

A final lesson from Vermont's efforts is the importance of addressing the underlying inefficiencies and problems in the health care system in order to improve health care outcomes and slow the rise of ever increasing health care costs. The Blueprint for Health has tremendous potential to transform Vermont's health care system from a reactive system (which treats people when they develop acute symptoms) to a preventive, proactive system (which works with patients and populations to reduce risks for disease and help manage those diseases in a planned care environment when they occur). These changes are slow and require sustained effort and commitment. The Blueprint reforms increase the chance that Vermont will end up with a more cost effective and high quality health care system, regardless of federal or state health insurance reforms. Many interviewees believe that Vermont's approach was actually more comprehensive than Massachusetts', despite the lack of an individual mandate in Vermont, because of its investment into care management and HIT and that Vermont will have better long term results in cost containment and coverage.

The majority of the informants we talked to expressed confidence that the Catamount Health Plan and Employer Sponsored Insurance Assistance programs would continue indefinitely into the future, eventually as programs within the health insurance exchanges mandated by the PPACA. The programs are overall well supported and too much has been invested in these programs for them to be cut altogether by the Governor or legislature in the near term. However, most also agreed that there would be ongoing reforms and modifications to these programs in order to improve them and/or to help bring them within current budget realities.

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VI. ASSESSMENT OF THE AFFORDABILITY OF HEALTH INSURANCE UNDER HEALTH REFORMS

FINDINGS FROM ENROLLMENT DATA

Introduction

As described in prior sections, Vermont's health care reform efforts during the past four years have increased enrollment in state-funded or state-sponsored programs. This has occurred as a result of the creation of a new insurance program, Catamount Health, and through increased promotion of existing programs and rebranding of programs.

In addition, the state created a program that shifts individuals from its existing Vermont Health Access Plan (VHAP). Under this option, individuals (currently on or applying for VHAP) who had access to adequate employer-sponsored health insurance (ESI) would be enrolled in the ESI plan, rather than VHAP. Overall ESI premiums did not change but the state covers the employee share of ESI.⁴⁵

This section describes enrollment in the Vermont health insurance programs as an indicator of program affordability for eligible Vermonters. In the discussion below, the following abbreviations will be used:

- CHAP – Catamount Health with premium assistance
- CH – Catamount Health without premium assistance
- ESIA – Employer-sponsored insurance for those otherwise eligible for Catamount Health
- VHAP ESI – Employer-sponsored insurance for those otherwise eligible for VHAP

Sources of Information

Approximately 3 weeks after the close of each month, the Department of Vermont Health Access (DVHA) issues a report that includes monthly enrollment information for CHAP, CH, ESIA, and VHAP-ESI.⁴⁶ While this information is very valuable for monitoring the success of Catamount and related programs, there are some challenges in using it.

The most significant challenge is in how enrollment is reported by income category. There are a number of adjustments to income that are made as part of the eligibility and enrollment process. For many Medicaid applicants, there is a disregard of up to \$90 per month in earned income to recognize the costs of working. There is also a disregard of

⁴⁵ Note that this initiative did not change eligibility requirements for VHAP, and is included as part of our analysis of VHAP.

⁴⁶ For context, enrollment information is also provided for VHAP, Dr. Dynasaur, and other Medicaid.

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the net costs of child care, up to \$175 per child per month.⁴⁷ The income used for determining eligibility is net of these disregards.⁴⁸

Further complicating this challenge is the \$400 earned income disregard that was put into place in 2008 for Catamount Health Premium Assistance and Catamount Employer Sponsored Insurance Assistance. This additional income disregard created in 2008 and taking effect in July, as discussed earlier in this report, does not affect eligibility for programs. It is used only to determine where Catamount Health beneficiaries who are eligible for premium assistance fall on the sliding premium scale. Implementation of this disregard created a discontinuity in reporting. This can be seen when the June 2008 and July 2008 enrollment by income are compared.

Additional, but far less significant, limitations to reported enrollment based on VHHIS analysis are the lack of inclusion of retroactive changes and the lack of information to changes in and out of programs from one month to the next (i.e. how many people newly enrolled and how many dropped off).

Enrollment in Existing State/Federal Programs

While determining the impact of new programs is relatively straightforward, determining the impact of rebranding and outreach efforts on *existing* programs is more difficult. The principal challenge in evaluating the impact of the rebranding and outreach efforts is to isolate those effects from the effects of broader economic forces.

It is worth analyzing enrollment trends in Medicaid and VHAP for the 31-month period between initiation of the program (November, 2007) and June, 2010. Enrollment trends, presented in Figure 1, increased significantly:

- Enrollment in traditional Medicaid (excluding VHAP) increased by about 9%, from 93,130 to 101,885 (8,755 people).
- Enrollment in VHAP (including VHAP ESI) increased much more rapidly (43%), from 24,884 to 35,496. This includes 926 people who enrolled in VHAP ESI. Note that VHAP ESI enrollment includes both new enrollees and transfers from the existing VHAP program.

The growth in VHAP is of particular interest as an indicator of the impact of rebranding and outreach efforts. While VHAP is only about one-third the size of traditional Medicaid, about 34% of new public program enrollees enrolled in this program, while only 27% enrolled in Medicaid (39% enrolled in the new Catamount programs: CHAP, ESIA, and unsubsidized Catamount).

It appears that the outreach and rebranding efforts may have been particularly useful in attracting individuals with incomes in the VHAP eligibility range. These individuals,

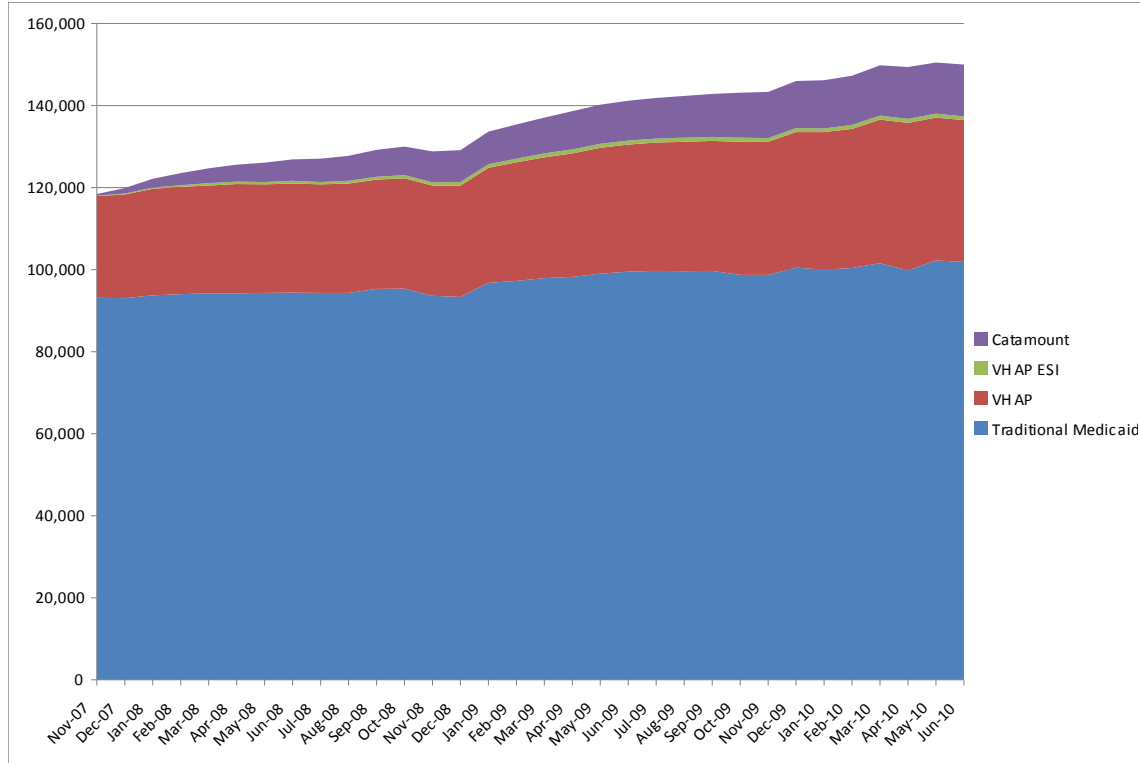
⁴⁷ \$200 per month for children under 2

⁴⁸ To analyze eligibility using the VHHIS we use gross income since we cannot accurately estimate net income to allow for estimation of income-specific take-up rates.

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who have higher incomes than the Medicaid-eligibles, previously may not have known the program was available, may have thought they would not qualify, or may have not been likely to apply for assistance due to the stigma of public programs. Interestingly, the growth in VHAP enrollment appears to have begun in January of 2007, prior to implementation of new programs or outreach efforts, following about three years of flat enrollment.

Figure 1: Enrollment in Vermont’s Health Care Programs, 11/07 – 6/10

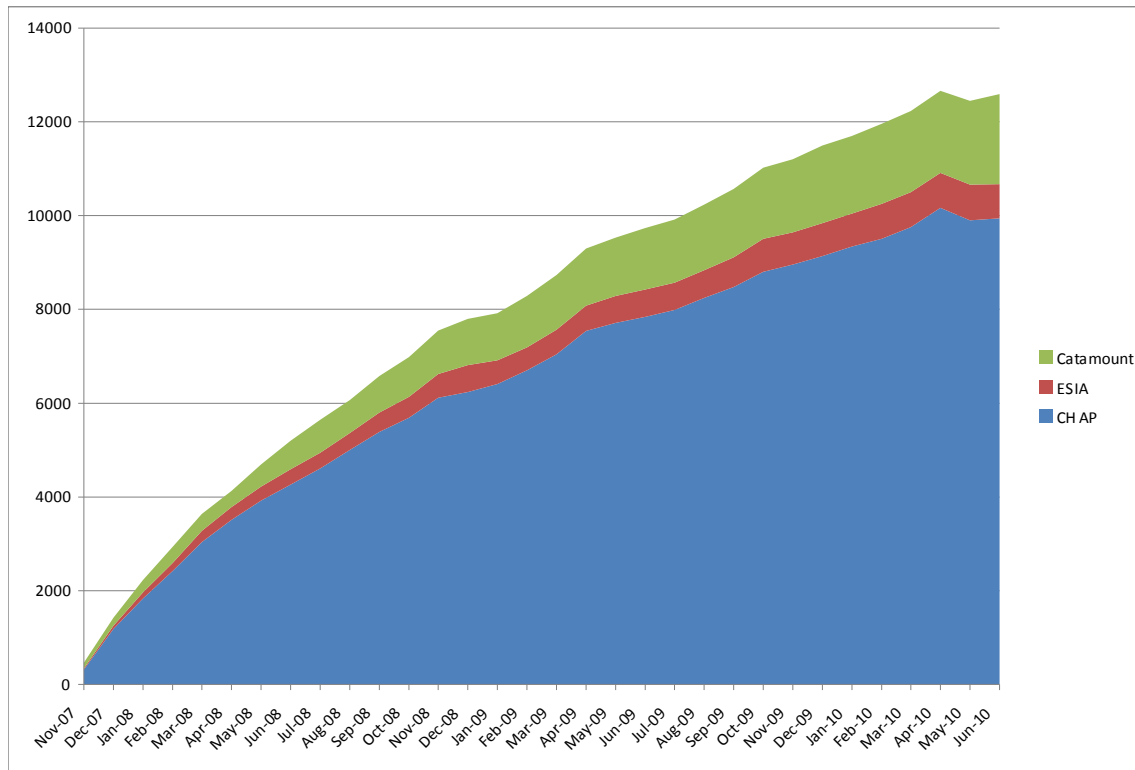


Enrollment in Catamount Health

As of June, 2010, about 12,600 Vermonters were covered under the three Catamount-related programs. About 79% of them are covered through Catamount Health with Premium Assistance (CHAP). About 6% are covered through subsidized employer-sponsored insurance (ESIA) and about 15% purchase Catamount Health at full cost. This distribution has remained remarkably consistent since the program’s inception.

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Figure 2: Enrollment in Catamount Health Programs



Initial enrollment in the program was quite rapid, with an average increase of 800 people per month during the first four months of operation⁴⁹. Since then, monthly increases have declined slowly, with new program enrollment nearly flat in the last four months. The three individual programs have seen nearly identical patterns of enrollment change.

Age

One of the major goals of the state’s outreach efforts was to attract uninsured young adults. Based on the most recent enrollment statistics, this effort appears to have been successful, especially in CHAP. About 22% of all CHAP enrollees are between 18 and 24 years old, and almost 40% are 35 or younger. The proportion in the younger age cohorts has actually been increasing slowly. Nearly one quarter of CHAP enrollees are between 55 and 64. ESIA enrollees tend to be somewhat older than CHAP enrollees, with only 10% of ESIA enrollees aged 18-24.

In developing their Catamount Health products, both insurers (MVP and Blue Cross Blue Shield) assumed that the age profile of purchasers would be similar to the age profile of the uninsured as a whole. For example, a higher percentage of the uninsured are 18-34 year olds. Insurers expected that this cohort would make up a large percentage of the purchasers. However, this has not been the case. While Catamount has been relatively successful in attracting younger customers, take-up has been substantially higher among those 35 and over. This pattern may have a significant impact on utilization of services

⁴⁹ Excluding November 2007

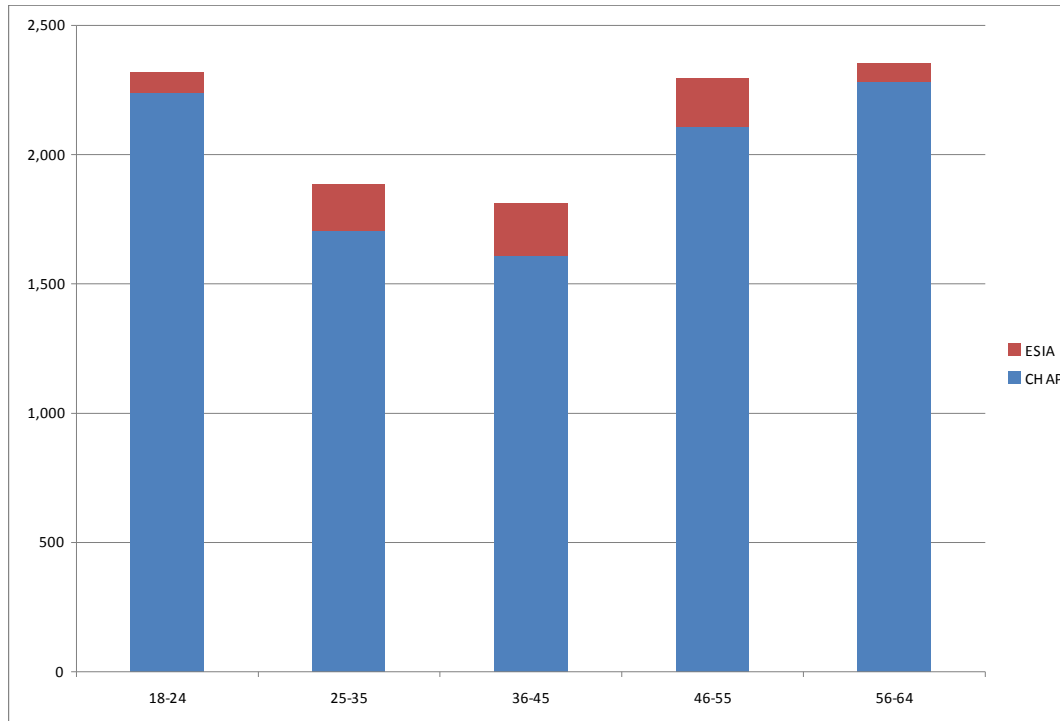
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and, subsequently, on the costs of the program (e.g., older people are more likely to require medical care than younger people). The trend in enrollment toward an older population may result in premium rate increases for the two products. Figure 3 presents enrollment in the new Vermont Health Care programs by age.

One of the findings of note is how the age distribution differs between CHAP and ESIA. ESI enrollment is proportionately highest in the 36-44 and 46-55 cohorts. This is probably due to an association between work history and access to ESI.

In contrast, enrollment in CHAP is proportionately highest among 18-24 year olds (note that there are fewer years in this cohort) and the two oldest cohorts. Factors that may be influencing this are a lack of access to ESI and heightened concerns about health among Vermonters over 45.

Figure 3: Enrollment in Vermont Health Care Programs by Age



Using September 2008 enrollment figures and information on the uninsured from VHHIS (which was fielded in September 2008), we have computed take-up rates for the Catamount Health programs by age cohort in Table 4 below.⁵⁰ In this analysis, take-up rates are computed as the number of enrollees in the cohort divided by the number of enrollees plus number of remaining uninsured eligible for Catamount Health. These take-up rates are only an approximation because eligibility cannot be exactly determined using survey data.

⁵⁰ 4 CHAP enrollees age 65 and over are excluded from this analysis.

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Table 4: Take-Up Rates for Catamount Health Programs

	CHAP	ESIA	Uninsured	Take-Up
18-24	969	50	12,096	7.8%
25-35	873	110	10,156	8.8%
36-45	979	115	8,846	11.0%
46-55	1,291	97	8,574	13.9%
56-64	1,261	41	3,622	26.4%

Income

It is worth examining Catamount Health enrollment by income to see which income groups are taking advantage of the program. Table 5 below and Figure 4 present enrollment in the Catamount Health plans by family income (as % of the Federal Poverty Level). Note that as discussed above, family income used in this table is NET of any disregards.

Table 5: Enrollment by Income Level

	CHAP	ESIA	Total	Percent of Total
<50%	514	2	516	4.1%
50%-75%	112	0	112	0.9%
75%-100%	137	4	141	1.1%
100%-149%	414	13	427	3.4%
150-185%	3700	236	3936	31.2%
185%-200%	2324	216	2540	20.2%
200%-225%	1340	153	1493	11.9%
225%-250%	859	63	922	7.3%
250%-275%	398	39	437	3.5%
275%-300%	145	3	148	1.2%
Over 300%	1924		1924	15.3%
Total	11867	729	12596	

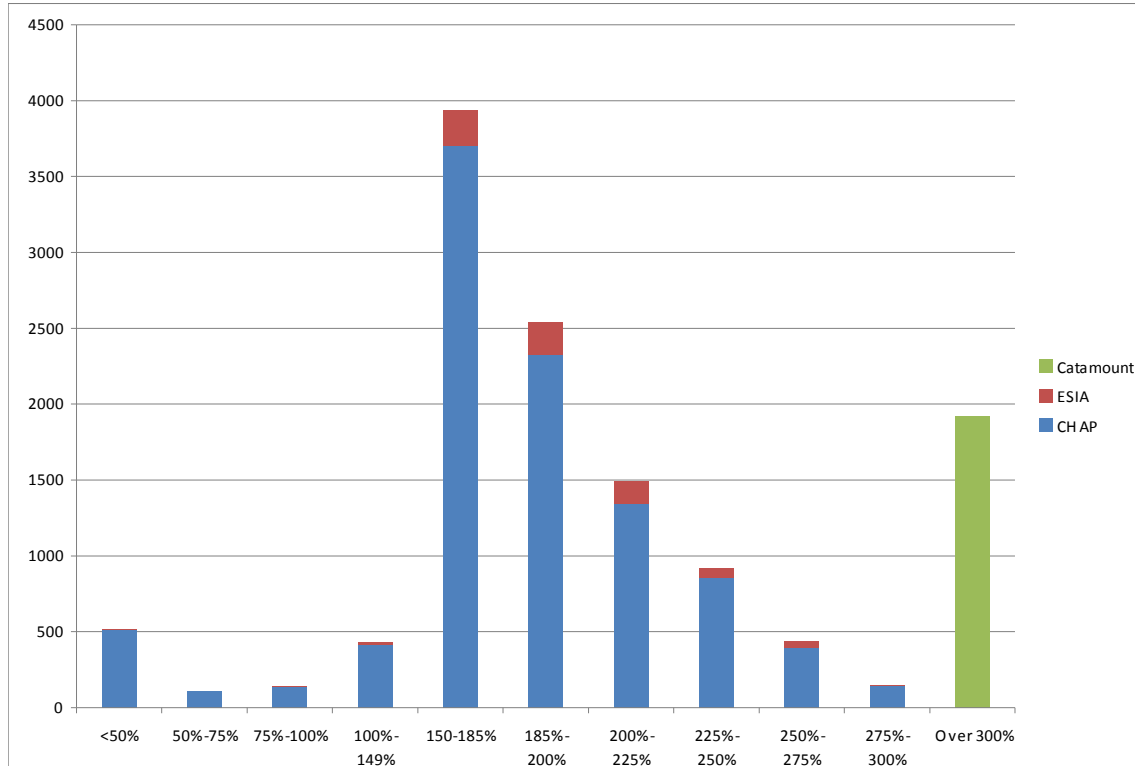
In June 2010, a total of 11,867 people were enrolled in Catamount Health. The enrollment data show some interesting trends by income:

- Approximately 16% of enrollees (1,924 people) have family incomes above 300% FPL and do not receive premium assistance.
- Approximately 10% of enrollees (1,177 people) have family incomes below 150% FPL. In most cases, these individuals would qualify for VHAP and would not enroll in Catamount Health, but there are limited circumstances, usually involving college students, where applicants are not eligible for VHAP but are eligible for Catamount Health.

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- More than half of Catamount enrollees have family incomes between 150 and 200% FPL.⁵¹

Figure 4: Enrollment in Catamount Health Programs by FPL



Market Share and Selection

About three-quarters of CHAP enrollees have chosen Vermont BlueCross BlueShield with the balance selecting MVP Health Insurance. This distribution has been very stable over time. Prior to April 1, 2010, premiums were identical for the two carriers. Currently MVP is about \$10 more expensive per month for a single policy. It is unclear why beneficiaries are selecting one plan over the other.

Starting October 1, 2010, Catamount deductibles will increase slightly. BISHCA recently approved BCBS rates for purchases or renewals during the period 10/1/2010 – 12/31/2010. That rate will be \$415.72 per month for a single plan.

Enrollment Changes

The monthly reports issued by the Department of Vermont Access (DVHA) include the number of people enrolled in the program each month, but they do not include any analyses of changes within the enrollment patterns. To explore the components of change and the patterns of enrollment and disenrollment, we requested a data file from DVHA that would include a non-identified record for each Vermonter who was ever on

⁵¹ Note that this is net of all income disregards. The \$400 earned income disregard, which is applied to beneficiaries between 200 and 300% of poverty (after application of other disregards) reduces an individual's FPL by 44% and a couple's by 66% (in 2009).

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Catamount Health. For each month from January 2007 to the most recent month available, the beneficiary's coverage status on the 15th of that month would be indicated. For beneficiaries who were enrolled in any state health care program, that program was identified. For months during which the beneficiary was not enrolled in any state program, no coverage was shown. Unfortunately, we are unable to distinguish between those beneficiaries who had obtained coverage from another source and those who were uninsured.

Components of Enrollment Change

While looking at monthly changes in enrollment can provide a picture of how Vermonters are utilizing Catamount Health, it is also valuable to explore the two components of change – new enrollment and beneficiary drop-off. For example, is the slowing of enrollment growth attributable to a decline in new enrollees or an increase in drop-offs?

One of the most striking findings was that the number of people newly enrolling in Catamount Health each month has risen slowly since the first month of the program, from about 650 to about 850, while the number leaving the program has increased every month. In the most recent two months, an average of just over 800 people left the program. The slowing of net increase in enrollment is primarily attributable to this increase in the number leaving the program each month.

Where Do New Enrollees Come From?

More than half of new enrollees in Catamount were previously covered by another state health program, most often the Vermont Health Access Plan (VHAP). VHAP is the state's 1115 waiver program that provides coverage to childless adults up to 150% of poverty who are not otherwise eligible for Medicaid. One of the design goals for Catamount was to provide "seamless" eligibility transfers with VHAP as income changes.

Where Do Drop-Offs Go?

The distribution of destinations for those who leave Catamount coverage is very similar to that of those who enroll. Slightly more than half leave state coverage, one-third move to VHAP, and the balance transfer to other state programs.

The importance of VHAP as both a source and a destination suggests that one important function of Catamount is to provide continuous coverage for those with irregular incomes around 150% of poverty. In the absence of CHAP, small increases in income would lead to loss of coverage. This pattern will be explored in more detail below.

Patterns of Coverage

The patterns of movement onto and off of Catamount remind us of the transitional nature of coverage for many. There is not a fixed uninsured population, whose numbers will be reduced by those moving onto a new program for a prolonged period. While a substantial number of people have enrolled in Catamount and maintained their coverage, for the majority, the coverage is brief and episodic.

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For example, according to an analysis by Vermont BlueCross BlueShield, a typical enrollment cohort (defined by initial month of coverage) will see a decline of between 4% and 8% each month for a year, until about 40% of the original enrollees remain. At this point, enrollment stabilizes.

Another way to describe patterns of coverage is to look at number of transitions (counting each enrollment and disenrollment as a transition). About 38% of those ever enrolled in CHAP have had only one transition (onto the program). Forty-seven percent have had 2 (on and off), 8% have had 3, 6% have had 4. . Some enrollees have had 9 transitions.

Of those ever on Catamount, 24% have not had coverage on any other state program (during the data period), 28% have been covered only by Catamount and VHAP, 29% by Catamount, VHAP, and other state programs, and 19% by Catamount and other state programs (but not VHAP).

In addition to actual enrollment data, the VHHIS asks several questions about interruptions in coverage in the past year of those currently insured. Using combined survey results from 2008 and 2009 (post reform), we were able to explore these interruptions in coverage among Medicaid, Catamount and Privately insured respondents in order to determine whether those in State subsidized programs were any more likely than those with other types of coverage to report interruptions in this coverage in the past 12 months. While 5.4% of those with any type of insurance (including Medicaid and Catamount) reported an interruption in their coverage in the past 12 months, 12.3% of those with other State Health Insurance (e.g. Medicaid, VHAP) and 26.6% of those with Catamount Health Insurance report having had an interruption in the past year. This pattern suggests that those on Catamount and other State subsidized programs are at much greater risk of having an interruption in coverage than those with private coverage or Medicare.

Take-Up Rates

One of the critical components that drove financial projections during the development of Catamount Health was take-up rate – of the uninsured in specified income cohorts, how many would enroll in Catamount Health at different premium levels.

Now that there is actual enrollment experience, it would be valuable to compare projected and actual take-up rates. However, there are a number of issues that must be addressed before this analysis is attempted.

The first is “What is the appropriate eligible population?” As we have seen, enrollment in Catamount does not come only from the previously uninsured (or those who had a qualifying event). The number of uninsured is a point-in-time estimate. How do we account for those who, in the absence of Catamount, would become uninsured (such as those who lose eligibility for VHAP due to an increase in income)?

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This problem can be understood by one interesting statistic – the number of people who have been on Catamount at any point since the initiation of the program is nearly equal to the estimated number of eligible uninsured prior to the creation of the program. Does this mean that the take-up rate is close to 100%?

The second is “Based on what income?” Available survey data is based on gross income, as estimated by the respondent. Enrollment information is reported based on income after a series of disregards, including an offset to earned income and the cost of childcare. We have attempted to simulate these disregards using survey data, but this has proven to be problematic. While assumptions can be made about the earned income disregards, it is impossible to know if the family actually makes use of childcare.

We have not yet figured out an approach to the first problem other than using the point-in-time uninsured count as the eligible universe. We are hoping to address the second issue either by getting access to enrollment distribution by gross income or by refining the model to make better use of survey data.

Outstanding Policy Questions

The patterns of enrollment and disenrollment have raised several central policy questions. These include:

- Are there ways of encouraging retention, parallel to the state’s successful outreach efforts?
- Are there continuity of care issues, especially among those who move back and forth between Catamount and VHAP? Challenges include different formularies and different benefits.
- Are there unnecessary administrative costs in the transitions between fully public programs and Catamount?
- To the extent that some of the transitions in coverage are need-based, are there challenges in establishing an adequate premium? Another way of asking the question – if enrollment was more continuous, would premiums be lower?

Future Enrollment

There is a great deal of interest in how enrollment in state programs will grow in the future. This interest has both a budgetary and policy basis. Under Vermont law, if less than 96% of Vermonters are covered by health insurance in 2010, the state will need to consider an insurance mandate.

Looking at VHAP enrollment, for which we have over 10 years of data, it takes several years for enrollment to level off. When VHAP enrollment did flatten out, it was in an economic environment that looked very different than the current one (in 2003).

It appears that Catamount enrollment is following a similar pattern, leveling off after 30 months. Based on this pattern, it is highly unlikely that Vermont will achieve its target of 96% coverage until Federal reform is implemented in 2014.

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FINDINGS FROM THE VERMONT HOUSEHOLD HEALTH INFORMATION SURVEY

Introduction

Another source of information about the affordability of the new health insurance programs created in Vermont's health reform is the Vermont Household Health Insurance Survey (VHHIS). Vermont contracted with Market Decisions, an independent survey research firm, to conduct this survey in 2005, 2008, and again in 2009 in order to measure the results of the health reform efforts and to assess whether the goal of 96% insured has been achieved. Although the HCAA legislation was passed in 2006, the new Catamount and ESI programs did not start enrollment until November 2007. Therefore, 2005 is considered pre-reform for our analysis and 2008 and 2009 post-reform. The 2008 survey reflected one full year of Catamount and ESI implementation and was repeated in 2009 in order to give a more comprehensive assessment of the results of the reforms. More details about the methodology and findings of the 2005, 2008 and 2009 VHHIS surveys can be found in the initial findings papers presented to the Vermont legislature.⁵²

In order to assess the impact of the reforms on the health insurance status of Vermonters we address four questions:

- Do the trends in health insurance coverage for Vermonters indicate an increase in public coverage between 2005, 2008, and 2009?
- Are observed increases in public coverage due to increased eligibility (e.g. newly eligible residents signing up for Catamount products) or increased take-up rates among already eligible residents (e.g. increased awareness and enrollment among already Medicaid eligible populations)?
- Is there evidence of crowd-out (migration to public insurance from privately insured residents) due to new program availability?
- How do Vermont's trends compare to the region (New England) and national trends in insurance coverage over this same time period?

This last question provides some indication of whether observed trends in Vermont's health insurance coverage are due to overarching regional or national trends versus changes that may be attributable to the efforts of the health reforms.

Trends in Health Insurance Coverage

In order to examine VHHIS findings between 2005 and 2009, we first examined the percentage of Vermonters with Any insurance, Public Insurance, Private Insurance, and those with No Insurance in each year. These findings are shown in Table 6.

⁵² **2008 Vermont Household Health Insurance Survey: Initial Findings**, Submitted to the Vermont General Assembly, January 15, 2009 Available at: http://www.bishca.state.vt.us/HcaDiv/Data_Reports/legislative_reports/VHHIS_Initial_Findings2008_01_15_09.pdf and 2009 Vermont Household Health Insurance Survey: Comprehensive Report, Submitted to BISHCA, January, 15, 2010 Available at: <http://www.bishca.state.vt.us/sites/default/files/VHHIS-2009.pdf>

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Table 6: Means and Differentials for Vermont Health Insurance Enrollment (All Ages)
2005, 2008 and 2009

	Any Insurance	Public Insurance	Private Insurance	Uninsured
Mean Value (Health Insurance Enrollment 2005)	90.2%	31.2%	59.0%	9.8%
Mean Value (Health Insurance Enrollment 2008)	92.4%	33.0%	59.4%	7.6%
Mean Value (Health Insurance Enrollment 2009)	92.4%	36.0%	56.3%	7.6%
Raw Differential (2009-2005)	2.2%*	4.8%*	-2.7%*	-2.2%*

* Difference is significant at p<.01 level

We defined public insurance to include all recipients of Medicaid, Medicare, VHAP, Dr. Dynasaur, Catamount Health with Premium Assistance, and Employer Sponsored Insurance with Premium Assistance. Private coverage includes those who have employer sponsored insurance, military insurance and those who purchase insurance in the individual and group markets with no public subsidies to pay for this insurance. Those who purchase Catamount Health without any premium assistance are included here. Those with both public and private insurance were counted as publicly insured in our analysis in order to fully examine the impact of Vermont's public coverage efforts. The uninsured were those who reported no form of insurance and the any insurance category combines both publicly and privately covered groups. As shown in Table 6, the percent of all Vermonters who were uninsured decreased by 2.2% between 2005 and 2008, a statistically significant reduction, and these gains remained unchanged in 2009, despite the recession.

For the remaining analyses in this report we only include survey responses from people aged 0-64, or the non-elderly population. We omitted adults aged 65 and greater from the analyses because they overwhelmingly have Medicare coverage, which in our analysis is a form of public coverage. Therefore, this cohort would have had nearly 100% public coverage in all years. In order to observe the effects of Vermont's health reforms on Medicaid program changes in this time period, we opted to leave this primarily Medicare cohort out of the analysis. The only Medicare recipients in the remaining analysis would be those under 65 that are categorically eligible. Excluding the 65 and over population from the analysis permits a focus on those most likely to be uninsured, who are therefore the target of health reform efforts, since Vermonters age 65 and older are eligible for Medicare coverage already. However, it also has the effect of decreasing the percentage of Vermonters with any insurance and increasing the percentage uninsured in the remaining analyses, by systematically excluding an overwhelmingly insured cohort. The results for insurance coverage among 0-64 year olds between 2005 and 2009 are shown below.

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Table 7: Means and Differentials for Vermont Health Insurance Enrollment (Age 0-64)
2005 - 2009

	Any Insurance	Public Insurance	Private Insurance	Uninsured
Mean Value (Health Insurance Enrollment 2005)	88.8%	21.3%	67.5%	11.2%
Mean Value (Health Insurance Enrollment 2008)	91.2%	22.6%	68.7%	8.8%
Mean Value (Health Insurance Enrollment 2009)	91.1%	25.4%	65.8%	8.9%
Raw Differential (2008-2005)	2.4%	1.3%	1.2%	-2.4%
Raw Differential (2009-2008)	-0.1%	2.8%	-2.9%	0.1%
Raw Differential (2009-2005)	2.4%*	4.1%*	-1.8%*	-2.3%*

* Difference is significant at p<.01 level

As Table 7 shows, the percentage of non-elderly with any insurance coverage in Vermont increased by 2.3% between 2005 and 2009 to a little over 91% covered, a statistically significant increase. Tables 8 and 9 below show coverage trends during the same time period for all of New England and the US using CPS data. In order to examine the trends in New England without the impact of health reform, both Vermont and Massachusetts were left out of the New England analyses. Additionally, in order to have comparable, stable CPS rates, particularly for the small New England region, we combined 2005 and 2006 data to compare to VHHIS 2005, and combined 2008 and 2009 CPS to compare to VHHIS combined findings for these years. Although health insurance enrollment increased slightly in New England during this time period, Vermont's increase of 2.3% was substantially greater than in the remainder of New England (excluding MA and VT), which increased less than 1%. Unlike Vermont or New England, health insurance coverage declined slightly in the US overall between 2005/2006 and 2008/2009.

Between 2005 and 2008, about two-thirds of the increase in Vermont's overall coverage came through increases in public coverage. However, in the year between 2008 and 2009, there were large increases in public coverage and a similarly sized decrease in private insurance. The result is that Vermont experienced a 4.8% increase in public health insurance between 2005 and 2009 compared to about 1% increases among publicly insured for New England and the U.S.

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Table 8 Means and Differentials for New England (minus VT and MA)
Health Insurance Enrollment (Age 0-64) 2005/2006 – 2008/2009

	Any Insurance	Public Insurance	Private Insurance	Uninsured
Mean Value (Health Insurance Enrollment 2005/2006)	88.0%	16.8%	71.2%	12.0%
Mean Value (Health Insurance Enrollment 2008/2009)	88.5%	17.8%	70.8%	11.5%
New England Raw Differential	0.5%	1.0%	-0.4%	-0.5%

Table 9 Means and Differentials for US Health Insurance Enrollment
(Age 0-64) 2005/2006 – 2008/2009

	Any Insurance	Public Insurance	Private Insurance	Uninsured
Mean Value (Health Insurance Enrollment 2005/2006)	82.9%	17.9%	64.9%	17.1%
Mean Value (Health Insurance Enrollment 2008/2009)	82.5%	19.1%	63.5%	17.5%
United States Raw Differential	-0.4%	1.2%	-1.4%	0.4%

These findings suggest that Vermont’s health reform efforts, including new health insurance products and increased outreach for existing Medicaid programs, are an important factor in the observed increases in insurance coverage for the state.

The findings for private insurance show that this coverage decreased in Vermont more than in New England or the U.S. This finding suggests that there may be some crowd-out occurring, whereby some of those who previously had private coverage have moved to public insurance once they became eligible or learned of their eligibility for these programs. The issue of crowd-out will be discussed further below. However, changes in work status, particularly during the 2009 recession, are likely also a factor in the loss of private insurance. Using the same CPS and VHHIS datasets for 2005 and 2009, we found that fulltime work declined more in Vermont (-9.2%) than in NE (0.2%) or U.S. (-0.4%) during this time period. An increase in part time work in Vermont (3.7%) partly accounted for this decrease but also led to big increase in Non-Working adults (5.4 %).

Public Coverage Trends

In order to better understand the increases in public coverage experienced in Vermont between 2005 and 2009, we examined changes in both eligibility for public coverage and enrollment in public coverage, or take-up, among populations with various demographic factors. Table 10 below shows the changes in eligibility and enrollment for public

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coverage in Vermont in 2005 and 2008 by household income, age, marital status, working status and employer firm size.

To determine whether increases in public coverage experienced in Vermont are due to enrollment of newly eligible participants versus an increase in enrollment among those who were previously eligible for public coverage under income limits prior to the HCAA, we include two columns in the table for each year of the survey. The first column is the proportion of the population eligible for public insurance (based on income and household size), and the second column is the proportion of those eligible covered by public insurance. The two columns on the right show the overall change between 2005 and 2009 in this second variable, proportion of those eligible for public insurance who currently have public insurance, across each of the demographic groups and the significance of these changes using t-tests.

This table shows that public insurance coverage rose for those with incomes below 175% FPL. Despite increased eligibility, the proportion of the population with public coverage did not rise in most newly eligible groups over 175% FPL. In the group between 200-300% of FPL, only about 21-30% of those eligible took up public coverage in 2009. By contrast, in the group between 175-200% FPL, take-up rates averaged close to 40%.

In all groups except those with incomes < 175%, the take-up rate among the newly eligible population was lower than the participation rate among those always eligible for public insurance. Participation in public programs rose substantially in the lowest income group (0-175%), even though almost everyone in this group had been eligible for public coverage before the recent expansions. This finding suggests that increased outreach to populations already eligible for public insurance in Vermont, may have led to an increase in enrollment into existing Medicaid programs. This may explain some of the increases in public coverage seen between 2005 and 2009 in Vermont. Table 10 also shows that increases in eligibility for public coverage were greatest among the populations aged 25-54, and among part-time workers and employees of very small firms.

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Table 10: Changes in Eligibility and Enrollment in Vermont's Public Insurance in 2005, 2008, and 2009 by Selected Characteristics
(Age 0-64)

Characteristic	Public Insurance (All Covered)						Difference in Proportion of Eligibles Insured (2009-2005)	Two-Sided Significance (p<.05)
	2005		2008		2009			
	Proportion of population Eligible for Public Insurance	Proportion of Eligibles Insured	Proportion of population Eligible for Public Insurance	Proportion of Eligibles Insured	Proportion of population Eligible for Public Insurance	Proportion of Eligibles Insured		
Household Income to Poverty Ratio								
0-175%	95.1%	56.1%	100.0%	62.0%	100.0%	64.6%	8.4%	*
176-185	77.1%	53.9%	100.0%	46.7%	100.0%	38.5%	-15.4%	
186-200	43.9%	68.9%	100.0%	39.6%	100.0%	32.2%	-36.7%	
201-225	46.1%	69.5%	100.0%	18.0%	100.0%	29.5%	-40.0%	
226-250	33.2%	55.0%	100.0%	22.3%	100.0%	24.9%	-30.1%	
251-275	36.7%	46.5%	100.0%	14.1%	100.0%	21.6%	-24.8%	
276-300	32.4%	30.3%	100.0%	10.2%	100.0%	28.0%	-2.3%	*
>300	4.1%	100.0%	3.9%	100.0%	6.9%	100.0%	0.0%	*
Top 25%	2.6%	100.0%	2.7%	100.0%	5.3%	100.0%	0.0%	*
Bottom	97.5%	56.3%	100.0%	63.9%	100.0%	65.6%	9.3%	*
Age								
0-17	63.0%	65.0%	58.5%	71.1%	59.6%	71.7%	6.7%	
18-24	55.3%	35.1%	67.8%	28.3%	65.2%	41.4%	6.3%	*
25-34	34.4%	48.9%	60.2%	35.6%	61.1%	44.9%	-4.0%	*
35-44	25.8%	55.9%	43.4%	37.6%	47.6%	40.6%	-15.3%	*
45-54	18.1%	61.5%	38.2%	39.6%	36.2%	45.7%	-15.8%	*
55-64	18.0%	75.8%	33.7%	41.0%	35.9%	48.4%	-27.4%	*
>65								
Marital								
Married	18.9%	57.1%	36.8%	33.4%	36.6%	38.7%	-18.4%	*
Single	46.7%	50.2%	64.8%	41.8%	65.8%	51.5%	1.3%	*

**Achieving Universal Coverage Through Comprehensive Health Reform:
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Characteristic	Public Insurance (All Covered)						Difference in Proportion of Eligibles Insured (2009-2005)	Two-Sided Significance (p<.05)
	2005		2008		2009			
	Proportion of population Eligible for Public Insurance	Proportion of Eligibles Insured	Proportion of population Eligible for Public Insurance	Proportion of Eligibles Insured	Proportion of population Eligible for Public Insurance	Proportion of Eligibles Insured		
Work Status								
Full-Time	19.0%	33.6%	34.7%	17.0%	34.8%	22.9%	-10.7%	*
Part-Time	30.0%	61.2%	54.6%	40.0%	54.8%	44.1%	-17.1%	*
Non-	55.5%	73.1%	68.2%	61.4%	67.1%	65.1%	-7.9%	
Firm Size								
<10	23.6%	47.4%	50.1%	34.6%	50.3%	39.2%	-8.2%	*
10-24	25.9%	41.2%	43.4%	25.1%	49.0%	32.5%	-8.7%	
25-49	17.2%	32.0%	39.7%	21.4%	40.6%	28.2%	-3.8%	*
50-99	19.7%	35.7%	38.1%	23.9%	39.1%	22.1%	-13.7%	
100-499	14.2%	33.6%	40.7%	15.4%	37.2%	25.8%	-7.8%	*
500-999	12.0%	39.7%	31.1%	18.9%	33.3%	13.6%	-26.1%	
>1000	18.0%	36.6%	32.7%	14.7%	30.6%	23.3%	-13.3%	
Total	36.7%	58.2%	49.4%	46.4%	50.3%	52.0%	-6.2%	

Accounting Decomposition

Another method used to examine whether changes in public coverage in Vermont are due to enrollment into Catamount and ESI programs among newly eligible enrollees versus increases in pre-existing Medicaid enrollment among those eligible prior to the reforms, is accounting decomposition. This approach focuses on the paths to enrollment in public or private insurance. Enrollment in public insurance depends on being eligible for this coverage and taking it up. We accounted for the changes in public and private coverage (and uninsurance) by decomposing take-up into the originally eligible group, the newly eligible group, and the never eligible group between 2005 and 2009. (Since no major eligibility changes occurred in 2008, this analysis focuses on the years that represent endpoints of the analysis only.)

Table 11 shows the results of the Accounting Decomposition comparing 2005 and 2009 coverage and eligibility for each of the four categories of insurance in our analysis: any health insurance, public insurance, private insurance and no insurance. The percent eligible for public coverage in 2005 and 2009 (always eligible) is contrasted with the percent eligible for public coverage in 2009 only (newly eligible) and those not eligible for public programs in any year (never eligible). Changes in all four insurance categories are examined within each of these three groups.

In 2005, 34.7% of the population of Vermont was eligible for public insurance, and in 2009, 46.6% was eligible. This increase in eligibility post 2005 would be expected due to the addition of Catamount and ESI programs for individuals and families up to 300% of the federal poverty level. However, simultaneous changes in population demographics had the effect of moving people out of the public insurance eligible population over time. Insurance coverage rates increased 5.2% among those who had always been eligible for public insurance between 2005 and 2009. Insurance coverage rates increased 3.5% among those who were newly eligible for public coverage between 2005 and 2008 but dropped back in 2009 for a combined increase in coverage of only 0.3%. Coverage rates increased 0.5% among those who were never eligible for public coverage and showed a similar pattern as newly eligibles. Uninsurance rates fell correspondingly.

For those in the always-eligible category, the increase in insurance came from a substantial increase in public insurance coverage (10.4%), offset by a drop in private insurance coverage (5.4%). These findings indicate that enrollment into existing Medicaid programs increased between 2005 and 2009 among those always eligible, suggesting that marketing and outreach in Vermont has been successful in reaching those already eligible but not signed up for public programs.

For those in the newly-eligible category, the small increase in insurance came from increases in public coverage (12%) and simultaneous decreases in private coverage (11.7%). For those in the never eligible category, there was an increase in public coverage, and private coverage decreased by 2.2%. These findings suggest that the availability of subsidized coverage may have been an important safety net for loss of private coverage, particularly in the context of the economic recession.

Table 11: Accounting Decomposition Table
(Age 0-64)

	2005	2008	2009	2005	2008	2009
Any Health Insurance Coverage	% Eligible	% Eligible	% Eligible	% Insured	% Insured	% Insured
Always Eligible for Public Coverage (2005, 2008, & 2009)	34.7%	32.7%	30.8%	82.3%	86.1%	87.5%
Newly Eligible for Public Coverage (2008 and 2009 only)	15.1%	14.7%	15.8%	82.9%	85.2%	83.2%
Never Eligible for public coverage	50.1%	52.6%	53.4%	95.1%	96.1%	95.6%
Public Health Insurance	% Eligible	% Eligible	% Eligible	% with public insurance	% with public insurance	% with public insurance
Eligible for Public Coverage in 2005 and 2008	34.7%	32.7%	30.8%	50.8%	58.1%	61.2%
Eligible for Public Coverage in 2008 only	15.1%	14.7%	15.8%	10.8%	12.8%	22.8%
Not eligible for public coverage in either 2005 or 2008	50.1%	52.6%	53.4%	4.1%	3.9%	6.9%
Private Health Insurance	% Eligible	% Eligible	% Eligible	% with private insurance	% with private insurance	% with public insurance
Eligible for Public Coverage in 2005 and 2008	34.7%	32.7%	30.8%	31.6%	28.0%	26.2%
Eligible for Public Coverage in 2008 only	15.1%	14.7%	15.8%	72.1%	72.5%	60.4%
Not eligible for public coverage in either 2005 or 2008	50.1%	52.6%	53.4%	91.0%	92.2%	88.8%

* Included in eligible for public coverage in 2005 and 2008 are all residents enrolled in Medicaid, VHAP, Dr. Dynasaur. Included in eligible for public coverage in 2008 only are all residents enrolled in Catamount Health receiving premium assistance

Oaxaca Decomposition

We repeat the analysis of changes in all three insurance types using a standard labor economics technique, the Blinder–Oaxaca decomposition, to confirm that our results are stable after considering overlaps among population categories and controlling for other changes.⁵³ These analyses decompose changes in coverage into changes in population characteristics and changes in propensities to obtain coverage. We performed this decomposition separately for any health insurance coverage, private coverage, and public coverage. We conducted regressions on VHHIS data for Vermont, on CPS data for New England (minus Vermont and Massachusetts), and on CPS national data. Similar

⁵³ [Reilly and Wirjanto 1999](#) K.T. Reilly and T.S. Wirjanto, Does more mean less?: The male/female wage gap and the proportion of females at the establishment level, *Canadian Journal of Economics* **32** (1999), pp. 906–929.

regression-based decomposition analyses of insurance coverage using the CPS data have been performed in prior research⁵⁴. We use the 2005 base year of the pairwise comparison (2009 is comparison year) as the point of reference. The basic formula for the Oaxaca decomposition is as follows:

$$HI^{09} - HI^{05} = X^{05} * (B^{09} - B^{05}) + B^{09} * (X^{09} - X^{05})$$

where *HI* measures health insurance, *X* is a set of regressors, and *B* is a vector of coefficients that give the probabilities of obtaining insurance for each *X*. In the analyses that follow, we include the means of 9 *X* variables: income (defined as percentage of FPL), age, gender, marital status, work status, employer firm size, health status, household size, and number of children in household. Regression results for each insurance type are shown in Table 12 below.

Table 12: Oaxaca Decomposition Regression Results (Age 0-64)

Oaxaca Decomposition – Any Coverage			
	Coefficients	Means	Total
Vermont	2.5%	-0.1%	2.4%
New England	-0.1%	0.0%	-0.1%
USA	-0.3%	-0.4%	-0.7%

Oaxaca Decomposition – Public Coverage			
	Coefficients	Means	Total
Vermont	4.4%	-0.3%	4.1%
New England	0.8%	0.2%	1.0%
USA	1.2%	0.5%	1.7%

Oaxaca Decomposition—Private Coverage			
	Coefficients	Means	Total
Vermont	-1.9%	0.2%	-1.8%
New England	-0.9%	-0.2%	-1.1%
USA	-1.5%	-0.8%	-2.4%

**Note that Vermont and Massachusetts are omitted from the New England and national samples. Coefficients may not sum to totals due to rounding.*

The Oaxaca decompositions suggest very different coverage changes occurred in Vermont, New England, and the United States overall. Coverage increased most in Vermont where there was a large expansion in insurance coverage compared with the rest of New England and the United States overall. Coverage increased by about 2.4%, while

⁵⁴ See [Acs 1995](#) G. Acs, Explaining trends in health insurance coverage between 1988 and 1991, *Inquiry* **32** (1995), pp. 102–110., [Long and Rodgers 1995](#) S.H. Long and J. Rodgers, Do shifts towards service industries, part-time work, and self-employment explain the rising uninsured rate?, *Inquiry* **32** (1995), pp. 111–116. and [Fronstin and Snider 1996](#) P. Fronstin and S.C. Snider, An examination of the decline in employment-based health insurance between 1988 and 1993, *Inquiry* **33** (1996), pp. 317–325.

it declined slightly in New England and somewhat more nationally. Most of this increase comes from a large rise in the propensity to take up any insurance coverage (2.5%). In particular, there was a substantial increase in the propensity to enroll in public coverage between 2005 and 2009 (4.4%). This is consistent with the enactment of the public health insurance expansions in 2006.

In each of the three samples (Vermont, New England, and the national sample), most of the change in insurance between 2005 and 2009 was caused by a change in propensity to take up coverage rather than a change in the distribution of the population. Nationally, changes in the distribution of the population were associated with a decline in private insurance of 0.8% and an increase in public insurance of 0.5%. This might be attributable in part to the economic recession. In each of the samples, changes in the propensity to take up coverage caused a decline in private insurance and a slightly larger increase in public insurance. The decline in private insurance is consistent with an increase in the cost of private insurance, which might have led some people to drop their coverage, even if their circumstances did not change. The increase in public insurance is consistent with the (modest) expansions in eligibility that occurred in various states during this period.

There was also a decline in the propensity to enroll in private insurance in Vermont between 2005 and 2009 of about 1.9%. This decline was greater than the corresponding change in New England, but not much greater than the national change (1.5%). The larger decline in the propensity to take up private coverage conditional on characteristics in Vermont is consistent with the existence of some coverage crowd-out.

The magnitude of potential crowd-out can be seen by comparing the change in the coefficients associated with public coverage to the change in the coefficients associated with private coverage. Comparing Vermont to New England, public coverage changes if the population distribution had remained constant would have meant a relative increase in public coverage of 3.6 percent (4.4 – 0.8) and a relative decline in private coverage of 1 percent (1.9- 0.9), implying that about 30% of the expansion might have been crowded-out. Comparing Vermont to the national figure, the relative increase in public coverage was 3.2 percent and the relative decline in private coverage was 0.4 percent, implying that 12.5% of the expansion might have been crowded-out. It is important to note in interpreting the crowd-out finding that no state has seen a significant increase in employer sponsored coverage during 2000 to 2008.⁵⁵

⁵⁵ Gould, Elise. "Employer-Sponsored Health Insurance Erosion Continues: Unabated declines in coverage since 2000 are expected to worsen through 2009." Economic Policy Institute Briefing Paper #247. Washington, D.C.: Economic Policy Institute, 2009.

FINDINGS FOR VERMONT EMPLOYERS' HEALTH COVERAGE AND TAKE-UP

Insurance rates within a state are affected by the propensity of businesses to offer employer sponsored insurance (ESI). In states where firms are more likely to offer coverage, residents will be more likely to gain coverage through employment. Additionally, if the employee share of ESI premiums tends to be lower and ESI plans tend to be more comprehensive, employees will be more likely to take-up insurance that is offered to them. Because these issues around ESI affect the likelihood that employees are insured, we explore typical health coverage offered by employers in Vermont and compare this coverage to regional/national trends.

Another key issue that warrants exploration in the future is the impact of Vermont's 2006 reforms on ESI coverage in the state. For example, were firms more or less likely to offer coverage after the reforms? Have typical ESI plans changed? A related question is whether employees were any more or less likely to take-up ESI post reform because of new State subsidized products or because of increases in cost-sharing unrelated to reform. This report presents 2006 (pre-health HCAA reform), contrasted with 2008 and 2009 (post-implementation) MEPS data on employer insurance coverage in Vermont to gauge the impact of reforms on the employer insurance market. New England and US trends are used as a comparison.

The State of Vermont Has a High Proportion of Very Small Businesses

The size of private sector firms influences whether firms are able to offer insurance to employees and the quality of the insurance plans that they are able to offer. A 2008 study released by the RAND Institute found that from 2000 to 2005, the economic burden of providing insurance increased for employers, particularly for the smallest firms, and that small firms offered plans of slightly lower quality than those offered by large firms.⁵⁶ Thus, states with a high proportion of small businesses may have a higher proportion of uninsured or under-insured and, thus, may face additional challenges in covering their populations.

Data from the national Medical Expenditure Panel Survey (MEPS) in Table 13 shows that Vermont has a higher percentage of very small firms (<10 employees) and a lower percentage of very large firms (>1000 employees) compared with the New England state average and the nation as a whole. The distribution of Vermont firms by employee-size remained constant across the three most recent years (CY2006, '08, '09) of the MEPS. Because Vermont's firms tend to be smaller than other states, including other New England states, Vermont may face unique challenges with respect to employer-based insurance.

⁵⁶ Kauffman-Rand Institute for Entrepreneurship Public Policy. Is the Burden of Providing Health Insurance Greater for Small Firms than for Large Firms. 2008. http://www.rand.org/pubs/research_briefs/2008/RAND_RB9340.pdf. Accessed June 1, 2009.

Table 13: Percentage of Private Sector Firms By Number of Employees, 2006, 2008, 2009.

Firm Size (Number of Employees)	Survey Year 2006:			Survey Year 2008:			Survey Year 2009:		
	VT	New England Average	National	VT	New England Average	National	VT	New England Average	National
< 10	64.4%	60.1%	57.8%	63.6%	59.9%	58.1%	65.9%	60.3%	57.2%
10-24	11.8%	12.5%	12.3%	13.0%	13.3%	12.1%	12.4%	12.5%	11.8%
25-99	8.1%	8.2%	8.2%	7.6%	7.6%	8.2%	7.2%	7.4%	7.9%
100-999	6.6%	7.4%	6.6%	5.7%	6.7%	6.9%	6.5%	7.0%	6.8%
1000+	9.1%	11.8%	15.1%	10.2%	12.5%	14.6%	9.3%	12.3%	14.8%

Data source: Medical Expenditure Panel Survey (MEPS), NCHS/AHRQ

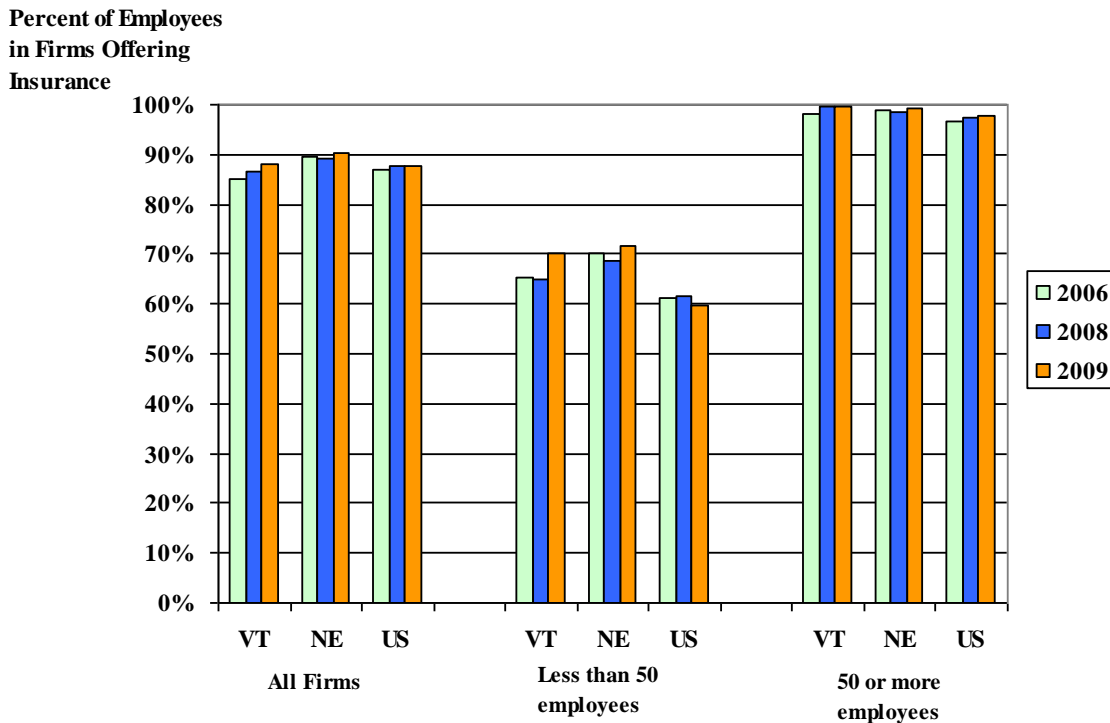
Vermont Employees Working for Firms that Offer Health Insurance Increased Relative to Regional or National Counterparts

As seen in Figure 5, 85.2% of Vermont's private-sector employees worked for firms that offer health insurance in 2006. This percentage was lower than the average percentage for New England states, at 89.4%, but similar to the national percentage, at 86.9%.

Vermont's percentage of private sector employees who worked for firms that offer health insurance increased to 86.4% in 2008 and increased further to 88.2% in 2009, although these increases were not statistically significant. In contrast to Vermont's increases, the New England state and national percentages of employees working for firms that offer health insurance remained within a narrow one percentage-point range of their 2006 levels during the 2008 and 2009 survey years.

The increased percentage of employees working for firms that offer health insurance was due in part to the rising percentage of Vermont small employers offering coverage (firms with <50 employees). As Figure 5 shows, compared with 2006 and 2008 figures, the percentage of smaller firms in Vermont offering health insurance increased from an average of 65.0% (average for 2006 and 2008) to 70.2% in 2009. Vermont's level of increase for smaller firms was not seen for New England (slight increase) or for the US (slight decrease).

Figure 5: Percent of private-sector employees in establishments that offered health insurance, by firm-size group, 2006, 2008, 2009.



Vermont Employees Working for Firms that Offer Health Insurance and Enrolling in Coverage Peaked in 2008

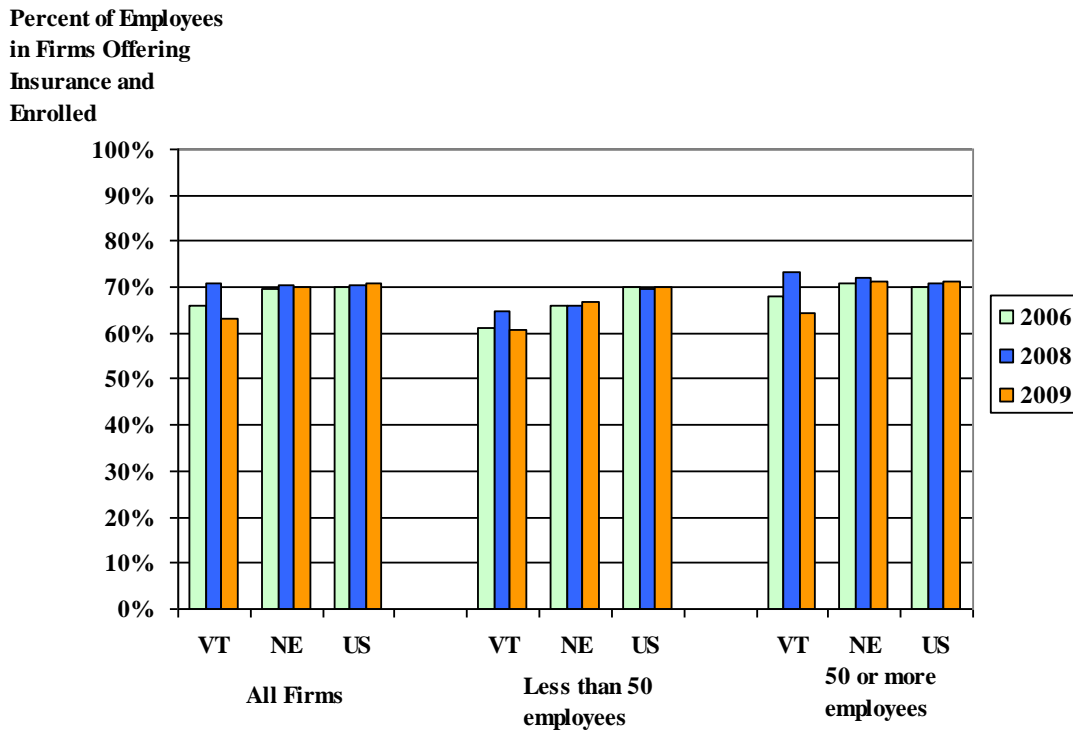
For full-time private-sector Vermont employees who worked at firms that offer health insurance, 65.8% enrolled in that insurance in 2006. By comparison, the 2006 New England average enrollment rates for full-time employees working at firms that offer insurance was significantly higher at 69.7%, as was the 2006 US average enrollment rate at 70.0% ($p < .05$). In 2006, Vermont enrollment rates for all firms, smaller firms and larger firms were lower than the New England and national rates.

By 2008, Vermont enrollment rates increased by 5.2 percentage points for all firms. The enrollment rate increases seen in Vermont for 2008 were not observed for New England or the US, where the change from 2006 to 2008 remained within one percentage point or less.

Enrollment data for 2009, however, indicate that full-time private sector enrollment rates in Vermont declined from 71.0% in 2008 to 63.2% in 2009. Although this decline was not statistically significant, the 2009 Vermont enrollment levels reverted back to levels observed in the 2006 Vermont enrollment rates. The enrollment rate declines were found for both smaller and larger firm-size employers. In contrast, the New England and US

private sector enrollment rates changed very little from 2008 to 2009, varying by one percentage point or less.

Figure 6: Percent of private-sector full-time employees that enrolled in health insurance at establishments that offer health insurance, by firm-size group, 2006, 2008, 2009.



The 2008 to 2009 decline in the percentage of Vermont private sector employees enrolling in health insurance at firms that offered insurance corresponds to the decline in private insurance during this time period reported from the VHHIS survey. The VHHIS survey results cited earlier in this report show a decline in the percentage of private sector health insurance enrollment (Figure 6), despite greater accessibility to coverage in the private sector (Figure 5). This may have been driven by a combination of public sector crowd-out effects and the impacts of the 2009 economic recession. The finding that Vermont patterns do not mirror those of New England and the US, despite the fact that the recession was nationwide, suggest that Vermont’s predominantly small employers’ health insurance decisions may have been more immediately impacted by recessionary cutbacks than large employers. However, Vermont’s changes over time did not reach statistical significance. This may indicate that this data source does not have the sample size in a small state like Vermont to adequately measure year to year employer sponsored insurance changes.

Health Insurance Cost-Sharing

It is important to study the cost-sharing aspects of employer-based plans for a variety of reasons. Employees who are enrolled in high deductible plans or plans with high copayments or coinsurance may be less likely to use services and, thus, may be

underinsured. In addition, if premiums are especially high, employers may find it more difficult to pay premiums or shift costs to employees. If employee share is high, fewer employees will enroll in the plans.

As seen in Table 14, the 2006 MEPS data shows baseline information about insurance cost-sharing patterns in Vermont prior to the passage of the HCAA.

- Total premiums for single and family coverage in Vermont were higher than the national average but lower than the average of the New England states. This indicates that, for a small state with many small businesses, Vermont was doing a good job in keeping premiums relatively low.
- The average employee contribution (in dollars) in Vermont for single and family coverage was lower than the average contribution in the national and New England comparison groups.
- There were some aspects of Vermont plans that did not compare favorably to New England and national comparison groups, however. Vermont employees were more likely to be enrolled in a health insurance plan that has a deductible, and the average deductible was higher than New England and national averages.
- Vermont employees with employer insurance were substantially less likely to have a copayment than New England or national comparisons.

By 2009, MEPS data indicate that several changes took place in Vermont's private sector health insurance cost-sharing structure.

- Total premiums for single coverage continued the pattern seen in 2006. Vermont premiums for single coverage were slightly lower than the New England state average but were higher than the national average. The cost of single coverage appears to have remained near their 2006 level of affordability.
- Total premiums for family coverage rose more steeply than did single coverage premiums. Vermont premiums for family coverage in 2009 were higher than either the New England or national average. The percentage of family premiums paid by employees also increased substantially from 22.5% of premiums in 2006 to 26.1% of premiums in 2009. The 2009 cost of family coverage appears to have become less affordable relative to 2006 costs.
- In 2009, the percentage of Vermont health insurance plans with deductibles was 70.8% --similar to the 72.5% Vermont figure for 2006. The New England and national percentages of plans with deductibles increased substantially between 2006 and 2009 and, by 2009, were more comparable with the Vermont's percentage of plans with deductibles. Dollar amounts for single and family coverage deductibles were greater for Vermont plans compared to their New England or national counterparts.
- As was found in 2006, Vermont employees were substantially less likely to be enrolled in plans with a copayment than New England or national comparison groups in 2009.

The 2009 changes in private sector insurance premium and cost sharing benefit structures indicate that Vermont private sector insurance premiums and employee out-of-pocket costs, formerly below the New England average in 2006, increased to a level that was at or above the New England average in 2009. Deductible levels for Vermont private sector health plans had been higher than New England in 2006 and continued to be higher than New England in 2009. Along with some public sector crowd-out effects and the impact of the 2009 recession, the increased costliness of the private sector health plans is a likely third driver of the 2009 decline in the percentage of employees enrolling in private sector health insurance coverage.

Table 14: Premiums, Deductibles, Co-pays and Coinsurance for Private Sector Employees with Insurance Through Their Employer, 2006, 2009

Measure	Survey Year 2006:			Survey Year 2009:		
	VT	New England Average	National	VT	New England Average	National
Premiums for Single Coverage						
Average total premium	\$4,322	\$4,509	\$4,118	\$5,001	\$5,116	\$4,669
Average total employee contribution for coverage	\$738	\$924	\$788	\$1,008	\$1,136	\$957
Percent of total premiums contributed by employees	17.1%	20.4%	19.1%	20.2%	22.2%	20.5%
Premiums for Family Coverage						
Average total premium	\$11,631	\$12,220	\$11,381	\$14,558	\$13,948	\$13,027
Average total employee contribution for coverage	\$2,619	\$3,006	\$2,890	\$3,793	\$3,734	\$3,474
Percent of total premiums contributed by employees	22.5%	24.5%	25.4%	26.1%	26.8%	26.7%
Deductibles						
Percent of employees enrolled in a health insurance plan that had a deductible	72.5%	54.9%	66.4%	70.8%	65.7%	73.8%
Average deductible for single coverage	\$936	\$707	\$714	\$1,393	\$965	\$917
Average deductible for family coverage	\$2,016	\$1,456	\$1,351	\$2,508	\$1,773	\$1,761
Copayment/Coinsurance						
Percent of employees enrolled in health insurance plan with copayment for office visit to a physician	67.8%	82.3%	74.9%	63.0%	77.2%	72.6%
Average copayment for employee enrolled in a plan with copayments	\$19	\$18	\$19	\$21	\$20	\$22
Average coinsurance (%) for office visit to a physician per employee with coinsurance	19.7%	18.3%	18.5%	18.9%	18.3%	18.6%

VII. SUSTAINABILITY

BACKGROUND

Program sustainability can be defined as financial sustainability – the ongoing balance between program revenues and expenditures – or in the broader sense as fiscal sustainability—the balance between direct program costs (or savings) and program’s impact on broader health system costs to the state and/or to other payers and providers. From either perspective, sustainability is central to successful health care reform. We will focus this evaluation on financial sustainability. Financial sustainability is particularly acute for states that cannot carry a deficit. The financing of Vermont’s reform efforts was designed to be financially sustainable for several years, but it was clear that longer-term financial sustainability would be a challenge, due in part to the use of funding sources such as cigarette and tobacco taxes that have been declining over time.⁵⁷

A program can be financially sustainable in two ways. The first is that dedicated revenue is fully adequate to cover operational expenses. The second is that supplemental funding⁵⁸ is available from other sources to cover operational shortfalls if dedicated revenues are inadequate.⁵⁹ Prior to the summer of 2010, operational revenues from the Catamount Fund were sufficient to cover expenditures. As of summer 2010, state General Fund dollars were needed to cover operational expenditures.

Financial sustainability is also dependent on how financing is structured. When a program is built entirely on dedicated revenues, the evaluation of sustainability is fairly straightforward – comparison of actual and projected revenues to actual and projected expenditures. In contrast, when a program’s revenues are, in part or in whole, determined by the legislative appropriation process, sustainability is more problematic because revenue is subject to political decisions in addition to economic factors. Most health insurance reforms carried out by state governments over the past thirty years have either failed or been drastically cut back because of this.

Financing in Vermont

The financing of Vermont’s health care programs has changed substantially over the years. Prior to 1992, the entire state share of Medicaid was appropriated directly from the state’s General Fund (GF). When the state implemented its first provider taxes in 1992, receipts from those taxes were deposited into a newly-created Health Care Trust Fund that provided additional resources for Medicaid. A second major dedicated fund, the Health Access Trust Fund (HATF), was created in 1996 and, at least initially, was

⁵⁷ With the expected onset of federal health reform, states are more likely to view sustainability in the short term; that is, they only need to capture enough funding for their health reform efforts to make it to a federal program.

⁵⁸ Defined here as funding which requires an explicit transfer from another source of revenue.

⁵⁹ Most health insurance programs sponsored by states rely upon fixed budgets from either dedicated revenues or general fund sources. Subsequently when funds run short, programs are usually cut back to ensure financial sustainability. When funds are plentiful, expansions occur.

used solely to support the state's Vermont Health Access Plan (VHAP), an 1115 waiver-based expansion of coverage to able-bodied childless adults. In state fiscal year 2003, the HATF became the major source of state funds for Medicaid and covered the state share of all spending in the Office of Vermont Access (OVHA) budget – about two-thirds of all state spending. In SFY 2005, the state received approval for its Global Commitment for Health 1115 waiver. All state funds in support of this program ultimately flow into a newly-created Global Commitment (GC) fund. General Fund dollars are directly appropriated to the GC fund, while other sources, such as cigarette and provider taxes, are first deposited into another new fund, the Health Care Resource Fund (HCRF), and then transferred to the GC fund.

Design of the Catamount Program

When Catamount Health was being designed, there were extensive discussions about whether to create a new fund to support the program. Ultimately, the legislature decided to create the Catamount Fund. Like the HCRF, the only purpose of this fund was to hold revenues that would be transferred to the Global Commitment fund to pay for premiums assistance and other costs associated primarily with the Catamount Health Program. The legislative goal was that the Catamount Fund—a combination of employer assessments, a share of cigarette taxes, and beneficiary premiums—would be adequate for the financial sustainability for at least the first three years of the Catamount Program. This estimate was based on financial modeling developed by the state at the time of passage.

In part, sustainability relied on beginning revenue collections well prior to the beginning of enrollment, creating a substantial cushion in the Catamount Fund. To further address sustainability, beneficiary premiums were set in a very different way than in other state programs. Unlike beneficiary premiums for other state health insurance programs that are only changed by legislative action, beneficiary premiums in Catamount Health were explicitly indexed to the cost of the underlying insurance product premium.⁶⁰

The Catamount Fund pays for many of the initiatives included in Vermont's recent reform efforts; however some reform components are funded from other sources. Specifically, the Catamount Fund pays for:

- Premium subsidies
 - State share, where federal Medicaid matching is available
 - Full cost, where matching funds are not available
- Administrative costs
 - Eligibility determination, enrollment, and premium payments for Catamount and Catamount ESI
 - Costs to administer the employer assessment
 - Marketing costs
- Other
 - Immunization program

⁶⁰ This was later amended to make beneficiaries who choose the more expensive Catamount Health plan fully liable for the difference in costs.

- Blueprint for Health (partial funding)

Program Operations

Two significant issues emerged in the early months of operation. The first was that one of the critical assumptions in program design was that the federal government would allow Vermont to amend its Global Commitment waiver to provide federal matching funds for all Catamount beneficiaries (up to 300%). While this approval was ultimately granted, initially the federal government approved the use of matched funds only to 200% of FPL, substantially increasing the burden on state funds. The second was that estimates of revenue from the employer assessment proved to be optimistic, so less revenue was available than was expected.

Vermont took several steps in response to the federal decision, including transferring additional General Fund revenues (State dollars) into the Catamount Fund and creating a new income disregard to lower beneficiary income, shifting many beneficiaries from the unmatched to the matched income cohort. The legislature made two substantial transfers from the General Fund to the Catamount Fund, although some of these funds were ultimately returned to the General Fund.

During early 2010, it became clear that the fund balance was becoming dangerously low. Projections indicated insolvency sometime in early FY 2011. In the Governor's proposed FY11 budget, he called for a significant increase in the Catamount Health deductible, which would lower the overall product premium. He further proposed that beneficiary premiums not be adjusted, so the benefit of the reduced total premium would accrue entirely to the state treasury.

The legislature accepted part of this proposal—increasing the deductible, but not as high as the Governor proposed. The remainder of the “revenue hole” in the Catamount Fund was filled with General Funds. However, these funds were appropriated directly to the Global Commitment fund, NOT to the Catamount Fund. This decision makes the evaluation of fiscal sustainability a bit more difficult to follow, as the same Global Commitment funds to support Catamount Programs will have to be disaggregated from those supporting other programs paid from the fund. All spending will continue to come from the Catamount Fund, but part of the revenue to support that spending will not be deposited in the fund. In other words, funding to maintain the program is adequate for another year, but the fund itself may become insolvent. The consequences of this are unclear at this time.

ANALYSIS

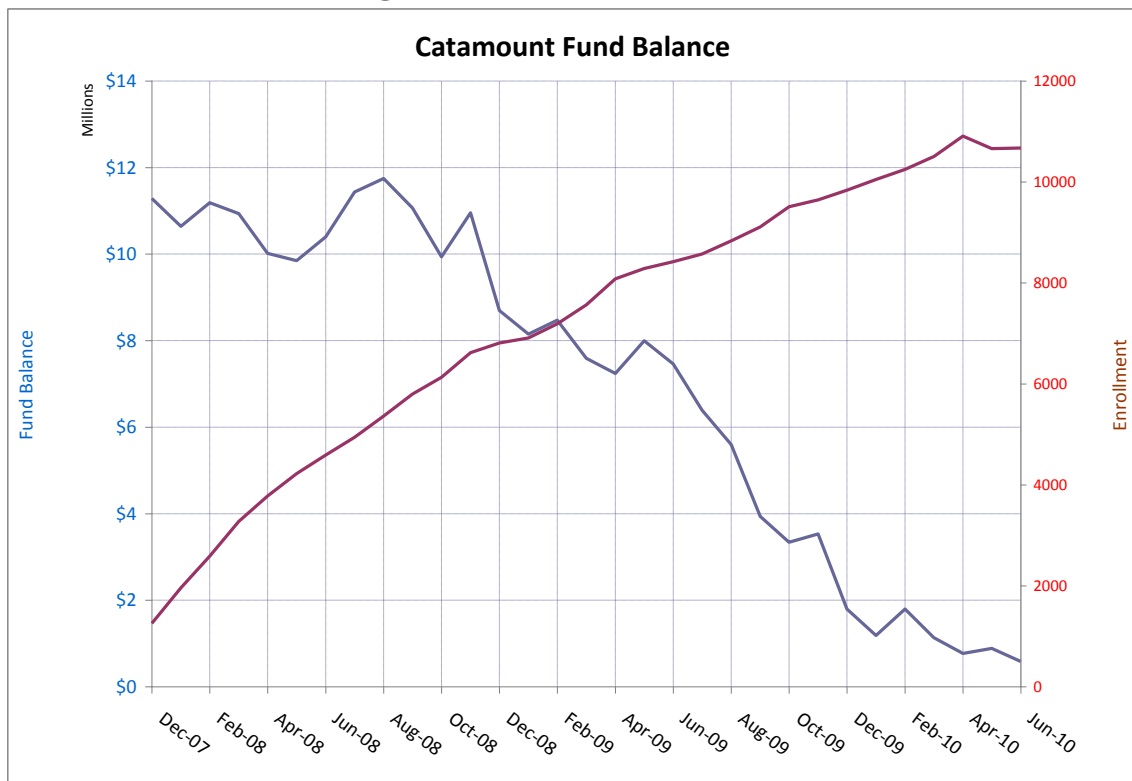
To assess financial sustainability we analyzed the Catamount Fund balance over several years. To do this we relied on detailed monthly reports from the Department of Health Access that include both revenues by source and expenditures by cost center. Data on program costs were then compared to the revenues from the identified sources. On the expenditure side, we initially expected to obtain data on both premiums and program claims. However, we later learned that the State only reports expenditure information for Catamount Health and the ESI program insurance premiums paid for by state and federal

sources. Claims costs are not reported to the state and can only be ascertained from Vermont’s new all payer claims database--VHCURES. VHCURES only just became available to the state—it was not available for this analysis of financial sustainability.⁶¹

Fund Balance

The fund balance is affected by three different factors – funds carried forward from the prior year, explicit transfers (both into and out of the fund) and operating results. A key part of the financial design was to create a substantial starting fund balance. Normally, programs run surpluses in early months just because enrollment growth tends to start out slowly. Vermont chose to add additional start-up funds by beginning revenue collection in fiscal year 2007, while beginning enrollment in early FY 2008.

Figure 7: Catamount Fund Balance



The effect of these factors can be seen in the first financial report issued by the state, covering operations through December 2007. There was a carry-forward from FY 2007 of \$4.6 million. A reserve, created to offset the impact of the loss of anticipated federal match up to 300% FPL, had a balance of \$3.5 million. State spending of \$4.4 million was offset by operating revenue of \$7.6 million, giving a fund balance of \$11.3 million.

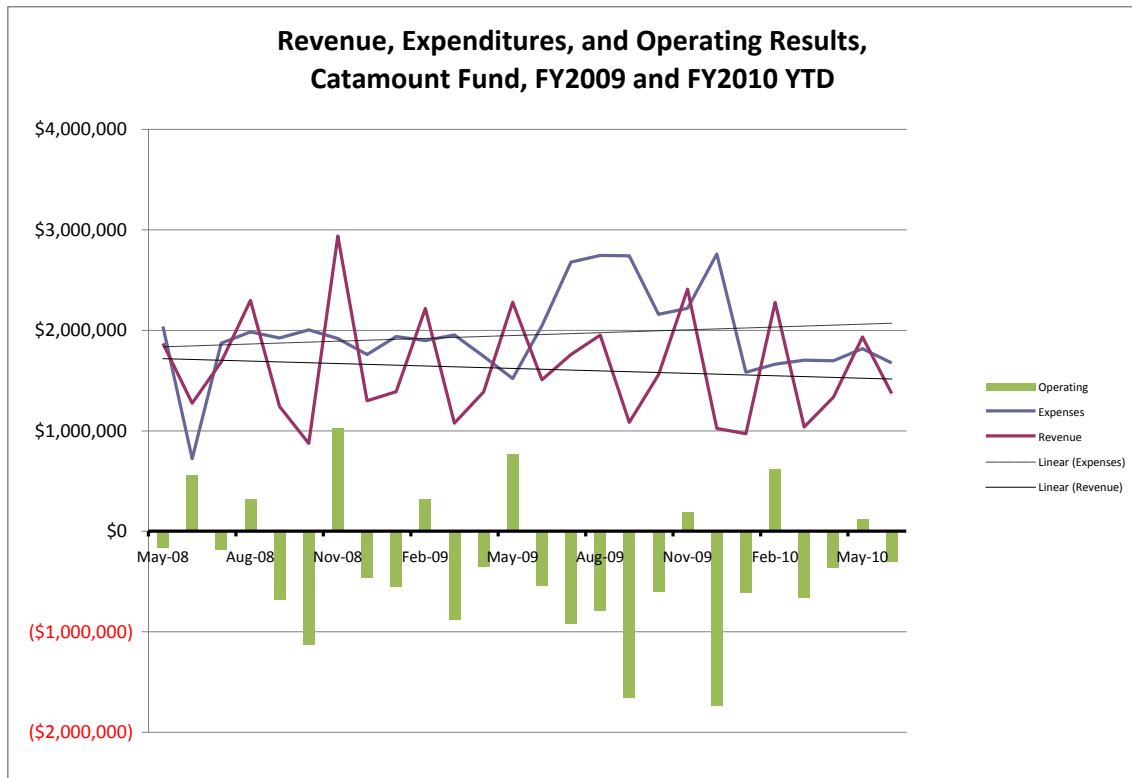
⁶¹ We anticipated having access to claims data in time for the Year 02 report. In addition to assessing sustainability from a cost-based perspective, we wanted to examine the contribution of the Vermont Blueprint and other reform efforts in reducing the costs of health reform by improving chronic care management and reducing demand for higher cost services. However, while our request has been approved, to date we have not received the data.

As shown in Figure 7 above, the balance declined slowly, ending FY 2008 at \$10.4 million. An additional \$1.8 million transfer to begin FY 2009 combined with a small operating loss in July of 2008 meant the fund began FY 2009 at about the same level as it began FY 2008. However, the combination of a retransfer of the \$1.8 million back out of the fund and about \$2.8 million in operating losses meant that the fund closed out FY 2009 with a balance of \$7.5 million. The fund balance at the end of FY 2010 was less than \$1 million.

Monthly Operating Results

An analysis of month-by-month results can be misleading. While expenses are fairly consistent from one month to the next, affected only by changes in enrollment and the timing of payments to insurers, revenue cycles vary. Payment of the employer assessment is done quarterly. This means that assessment funds are received primarily every three months, with minor collections in interim months. Cigarette and tobacco tax revenues show substantial variation from month to month, but this appears to be random and is probably the result of the collection process.

Figure 8: Monthly Operating Results for FY2009

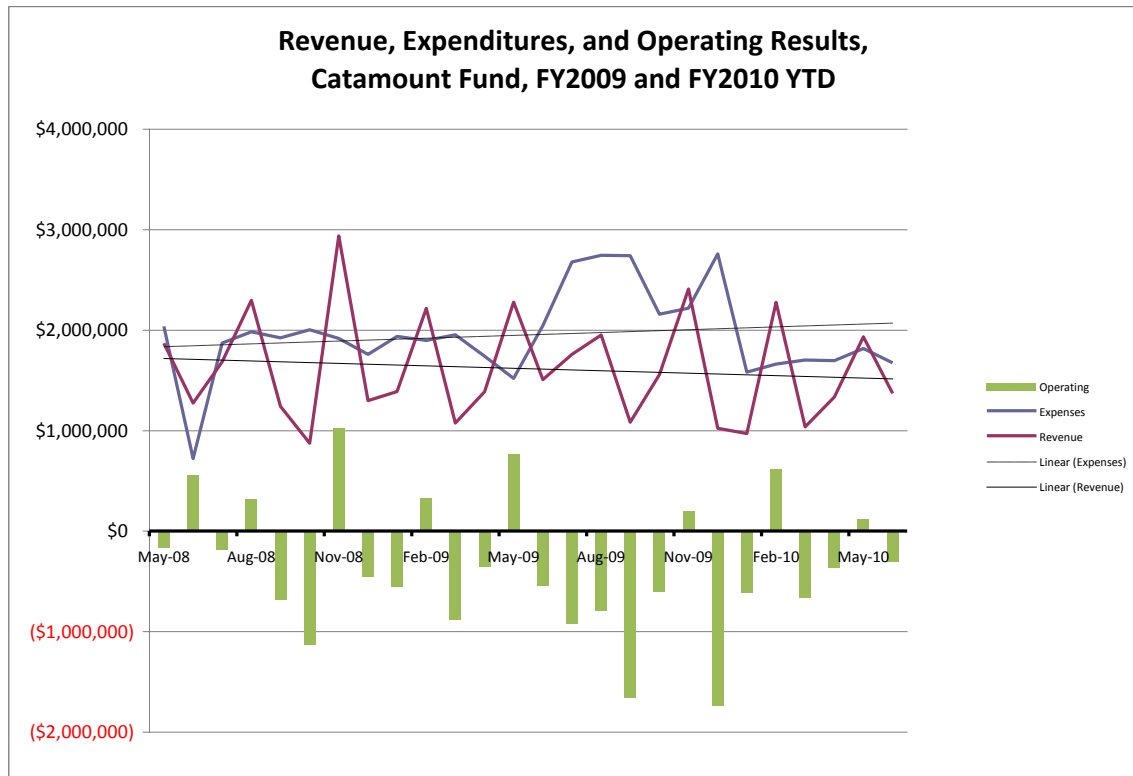


Examining only fiscal year 2009 in Figure 8 (to avoid the distortions of the changed income disregard) the challenges become apparent. Operating results were negative in seven of the ten months but, more importantly, while expenses are fairly flat (based on the results of the linear regression), revenues are both lower than expenditures to begin with and declining.

Cumulative Operating Results

One way to get a better high-level sense of operating results is to examine them cumulatively – to add them up over time. If a business or program is going to be financially sustainable, we would expect to see an upward slope or at least a flat slope (break-even). It is clear from this chart that on an operational basis, expenditures from the fund are substantially higher than revenues. Spending has used up the “cushion” that was created by early revenue collection. Without the supplemental transfers into the fund, it would be insolvent.

Figure 9: Cumulative Operating Results, Catamount Fund



Sustaining the program until Federal Health Reform – the Immediate Future

Currently, the Catamount Fund is in a serious decline, and no new revenue sources will be used to infuse it. It closed out FY 2010 (June 2010) with a balance of less than \$1 million, and despite the change in benefits and major infusion of cash, the FY 2011 budget assumes that the fund balance at the end of that fiscal year will be \$0. However, this is of little consequence if the legislature and the executive branch fund any short fall through additional General Funds—either directly to the Global Fund or through the Catamount Fund.

This decline in the CF is not surprising as it relies on a declining revenue source (the cigarette tax) to fund a program that historically increases in cost above the general rate of inflation. After an extended period without increases by the carriers, both MVP and BCBS have filed for premium rate increases.

The pace of participant enrollment in the program is uncertain and might offer some relief despite declining revenues. Until recently, it appeared that substantial enrollment growth would continue. However, in the last four months, enrollment appears to be leveling off. Whether this is a temporary phenomenon or the program has achieved equilibrium will have a major effect on finances. Since projections were for continued growth, a leveling-off of enrollment could be good news, at least on the financial side.

The state has also received some good news from CMS – the proposal to amend our waiver to permit the use of matched federal funds for premium subsidies for beneficiaries up to 300% of poverty has been approved. This has already been factored into the FY 11 budget, but it does mean that spending will slow.

The Longer Term

Financial sustainability for the period between now and 2014, when the federal mandate goes into effect, is extremely difficult to predict. For example, as a guaranteed-issue health insurance state, Vermont does not need to develop an interim high risk insurance pool to cover people with pre-existing conditions. However it would like to obtain federal resources in lieu of this to be used to shore up the financial sustainability of Catamount Health. It is unclear if this is possible.

Vermont stakeholders were aware of the sustainability problem long before federal health reform passed. Prior to the January 2010 legislative session, they commissioned a study to assess different administrative options available that would lower the cost of Catamount Health to the state and thereby improve financial viability of the health reform programs.

The study examined the administrative costs, affordability, enrollment process and financial sustainability of Vermont's Catamount Health Insurance Program. A particular focus was to assess the cost effectiveness of potential options for reducing administrative expenses to make more funds available for patient care. The study, conducted by the University of New England's Center for Health Planning, Policy and Research had the following findings:

- The enrollment process is complex and can require several intermittent enrollment steps depending upon one's eligibility status for premium assistance through either Catamount Health with premium assistance (CHAP) or employer sponsored insurance with premium assistance (ESIA).
- There are a number of applicants who start but do not complete enrollment. However, the size of this population is unknown, and there is little information on how many applicants do not complete because of the complexity of the enrollment process.
- Substantial enrollment churning occurs among CHAP enrollees where CHAP enrollees move between CHAP and other public coverage programs, private insurance or no insurance.

- Reasons for Catamount disenrollment are primarily due to premium cost, enrolling in another public health insurance program or enrolling in private insurance.
- Affordability of Catamount premiums, as measured by premiums as a percentage of income, varied from 2.8% of income for enrollees at 200% of the Federal Poverty Level (FPL) to 5.8% of income for enrollees at 300% FPL.
- Compared to the Massachusetts Connector affordability standards, Vermont Catamount premium paid by enrollees as a percent of income were very similar to the Connector affordability standards.
- Total estimated FY 2010 administrative expenses for the Catamount program, including Health Plan and OVHA expenses are nearly \$6.6 million.
- Administrative expenses as a percent of total Catamount enrollee expense was 8.7% for BCBSVT covered enrollees and 13.6% for MVP covered enrollees
- Accounting for added OVHA administrative functions, administration percentages increase to 11.8% for BCBSVT covered enrollees and 16.6% for MVP covered enrollees.

Five administrative change options were examined to measure their potential to reduce administrative expense. However, the state did not act on these, in part because federal health reform was passed in early Spring 2010 and in part due to known political opposition.

VIII. CONCLUSIONS AND NEXT STEPS

Summary of Findings

The process evaluation was used in order to glean insights and experiences to date about Vermont's new, public-private hybrid insurance product, Catamount Health, as well as other aspects of the reforms. Overall, we found most key informants supported the legislation and were generally satisfied with enrollment levels to date, despite the fact that original enrollment projections had to be revised downward after the first few months of Catamount implementation.

Some of the barriers to enrollment cited by key informants include: the affordability of the plan, particularly for those individuals who do not qualify for premium assistance; the 12-month waiting period for coverage; and the difficulty of the eligibility determination and enrollment processes. Implementation of the HCAA, however, has been viewed as an ongoing experiment of sorts, and at least 5 bills have been passed to date to modify and clarify the original HCAA health reforms and address these barriers.

Key stakeholders generally expected that there will be additional changes to the reform efforts in the coming years but also expect that newly-created programs like Catamount will continue into the foreseeable future, possibly as the subsidized insurance offering in the federal health reform's health insurance exchanges. Those with whom we spoke also acknowledged that there remain many unanswered questions at this point regarding the financial feasibility and the ideal mechanisms for financing state health reform efforts. Informants remain optimistic that additional support for the programs will be received from the federal government in the future, especially in light of the 2010 PPACA. However, Vermonters continue to forge their own path forward as evidenced by the passage of Act 128 which, among other things, provides funding for exploration of a single payer model in Vermont.

In order to provide an indication of the affordability of Vermont's new programs, we examined enrollment using program administrative data and changes in health insurance coverage using Vermont household survey data from 2005 to 2009. Despite the barriers cited above, enrollment in the new Catamount Health program increased sharply and steadily during the initial months. By June, 2010, a total of 11,867 people were enrolled in Catamount Health. Most of these enrollees receive premium assistance. Only 16.2% of enrollees have family incomes above 300% FPL and do not receive premium assistance.

Between 2005 and 2009, the percentage of residents under age 65 with some type of insurance coverage in Vermont increased by 2.4%. Currently, more than 91% of non-elderly residents are covered by insurance and more than 92% of all residents, including those 65 and older, are covered. Insurance coverage in Vermont has increased more rapidly than it has in other New England states. Most of the increase in Vermont's overall coverage came through increases in public coverage, suggesting that Vermont's

health reform programs may be a factor in the observed increases in insurance coverage for the state.

Although Catamount Health has played a role in reducing the percentage of uninsured Vermonters, it has not been the only factor. An aggressive outreach campaign has also been important because it has 1) spread knowledge about both new and existing programs and 2) facilitated enrollment in state programs. Our analyses show that participation in public programs rose substantially among those who had been eligible for public coverage before the recent expansions. Insurance coverage rates increased 5.2% among those who had always been eligible for public insurance. In comparison, coverage rates increased more moderately among those who were newly eligible (0.3%) or never eligible (0.4%) for public coverage.

These data suggest that increased outreach to populations already eligible for public insurance in Vermont may have led to an increase in enrollment into existing Medicaid programs. Outreach to those who were eligible for VHAP but who may not have known about the program (or may not have thought they were eligible) appears to have been particularly effective, as enrollment in traditional Medicaid increased by 9%, while enrollment in VHAP increased by 39%.

Sustainability of Vermont's health reforms is an important issue to the State and outside observers. The state began to acquire revenues for health reform prior to the implementation of most programs covered. This was done in part to build up a reserve to cover the costs of Catamount Health and other programs that require a lead time to be sustainable. As of December 2007 following the initial roll-out of CH, the Catamount Fund balance was approximately \$7.6 million. Since December 2007, the fund balance has declined as program revenues are not keeping pace with expenditures. Without legislative action during the 2010 session, the projected fund balance in August of 2010 would have been negative. The information presented here indicates that program financial sustainability as a function of premium expenditures versus tax and other revenues is not currently viable in the long term. However, we have yet to explore fiscal sustainability from the perspective of actual claims costs to carriers providing insurance. We have also not assessed the larger issue of overall value of health reforms to health status improvement (early detection and treatment of health conditions) and utilization and costs of care.

Limitations of Current Analysis

Although this report provides much information about Vermont's experience to date with health reform, there are limitations to this evaluation report due primarily to unavailability of some needed datasets, the limited amount of time that has elapsed since implementation of the new programs, and the not yet well understood impacts of the recently passed PPACA on state level reform efforts.

Our analysis is limited to datasets available at the time of report preparation. In some cases, such as with the Vermont Fringe Benefit Survey, the planned survey was not funded after 2007. In other situations, datasets which we had anticipated becoming

available during the evaluation period, such as the VHCURES claims dataset, were delayed and not available to be analyzed in time for this report.

Despite these limitations, Vermont's reform approach looks promising as a vehicle to provide access to health insurance for a population that had no insurance prior to the implementation of this legislation. This report offers important perspectives on the formation, passage and experience to date of Vermont's health reform legislation. It also includes analyses of enrollment, affordability, and sustainability of Vermont's new health coverage programs. This information provides valuable insights to inform future reform efforts in Vermont and other states, as well as a preview for the federal experiment with health care reform legislation.

IX. APPENDIX 1 - LIST OF KEY INFORMANTS

	<u>Year 1</u>	<u>Year 2</u>
<u>Vermont State Administration</u>		
Susan Besio Director Office of Vermont Health Access (OVHA) Vermont Health Care Reform	X	X
Tom Douse Deputy Commissioner Department of Labor	X	
Betsy Forrest Director Catamount and ESI Premium Assistance Programs OVHA	X	X
Dian Kahn Director of Analysis and Data Management Department of Banking, Insurance, Securities & Health Care Administration (BISHCA)	X	
Christine Oliver Deputy Commissioner Division of Health Care Administration BISHCA	X	X
Herb Olson General Counsel BISCHA	X	
Val Rickert Director, UC & Wage Department of Labor	X	
Joshua Slen Interim Director Vermont Information Technology Leaders (VITL)	X	
Kevin Veller Director of Health Care Reform Outreach & Enrollment OVHA	X	X

<u>Vermont Legislature</u>		
Senator Jane Kitchel	X	
Representative Steven Maier Chair of House Health Care Committee (past and current)	X	
Representative John Tracy Former - Chair of Health Care Reform Committee Current - Aide to U.S. Senator Patrick Leahy	X	
<u>Non-Governmental Stakeholders</u>		
Denis Barton Vermont Director of Public Policy Bi-State Primary Care Association		X
Hunt Blair Former - Vermont Director of Public Policy Bi-State Primary Care Association Current - Deputy Director of Health Care Reform Office of Vermont Health Access	X	X
Donna Sutton Fay Chittenden County Field Staff Vermont Campaign for Health Care Security Education Fund	X	X
Kevin Goddard VP of External Affairs Blue Cross/Blue Shield Vermont		X
Bea Grause Executive Director Vermont Association of Hospitals & Health Systems	X	X
Jim Hester Former VP for MVP HealthCare Current Director, Legislative Commission on Health Care Reform	X	X
Jeanne Keller Keller and Fuller, Inc		X
Trinka Kerr Staff Attorney Health Care Ombudsman Office		X
<u>Non-Governmental Stakeholders (continued)</u>		

Bill Little VP of Vermont MVP Health Care	X	
Lila Richardson Legal Counsel Vermont Coalition for Disability Rights (VCDR)	X	X
Kate Simmons Acting Vermont Public Policy Director Bi-State Primary Care Association	X	
Jennifer Wallace-Brodeur Associate State Director, State and Community Development AARP Vermont	X	X

X. APPENDIX 2 – PROCESS EVALUATION DOMAINS & QUESTIONS

Dimension	Study Questions	Overarching Interview Domains	Interview Questions
<p>Process Evaluation</p>	<p>Description of the policy context of the program design initially</p> <p>Program implementation/ experience to date and modifications required</p>	<p>Background on Catamount legislation (e.g., differences between what was initially proposed and what was passed; politics behind the eventual structure of the policy; politics behind projection modeling that was done)</p> <p>Extent to which reforms have been implemented</p> <p>Changes in policy that have occurred since initial legislation</p> <p>Extent to which goals, objectives, and outcomes of legislation have been met</p> <p>Lessons learned during implementation</p> <p>Perspectives of insurers on how</p>	<p>Description of the policy context of the program design initially</p> <ul style="list-style-type: none"> • What environmental and political factors contributed to the initial passage of the health reform initiative? (e.g., previous programs already in place, politics in legislature/governor’s office, other competing proposals) How have these factors changed since implementation? • How was the program’s breadth/depth of coverage and benefit features determined? How were subsidy eligibility levels arrived at? • What were the perceived trade-offs between public cost and access? • How is the program financed and how was the source of funding negotiated/arrived at? • Who were the major proponents/opponents to the reform proposal? For the opponents, what were the major concerns raised? • How did the changes in program design from the original proposal to the final version affect your support for the bill? <p>Program implementation/experience to date and modifications required</p> <ul style="list-style-type: none"> • How have the goals of the legislation been achieved to date? • Have all the proposed reforms been implemented and, if not, why not? • Are people participating in the program as expected (i.e., in Catamount Health, in ESIA, in Medicaid)? • Since implementation, have there been program design changes and, if so, what are they and what was the impetus for these changes? • What major lessons have you learned thus far? • What do you see as the next steps for greatest challenges facing healthcare <p>For Insurers:</p> <ul style="list-style-type: none"> • What role, if any, did your company played in development of the

Dimension	Study Questions	Overarching Interview Domains	Interview Questions
	<p>otherwise be privately insured (crowd out)?</p> <p>How have the health reforms impacted premiums and out-of-pocket costs?</p>	<p>Perceptions of private insurers about Catamount Health</p> <ul style="list-style-type: none"> • Voluntary/mandatory participation requirement • Whether it is an opportunity or obligation to have CH as part of portfolio • Whether new \$10,000 deductible eligibility has moved much business from other lines • How actual enrollment compares to projected (e.g., was risk mix better, worse, or as expected) 	<p>For Insurers:</p> <ul style="list-style-type: none"> • What changes, external to Vermont’s Health Reform, have occurred in Vermont’s private insurance market since 2005 that may explain changes in rates of uninsurance? • How do you feel about the voluntary/mandatory participation requirement? • Do you perceive it as an opportunity or obligation to have CH as part of portfolio? • Has the new \$10,000 deductible eligibility moved much business from other lines? • How does actual enrollment compare to what you projected (e.g., was risk mix better, worse, or as expected)? <p>Year 2 Only</p> <ul style="list-style-type: none"> • How does re-enrollment work for Medicaid, VHAP, and CHAP? Are individuals automatically re-enrolled or do they have to initiate re-enrollment? • How do you interpret the enrollment findings which show a lot of transitions on and off the program for most participants? • Have you heard any feedback from participants in CHAP or other State-funded health programs regarding losing coverage or dropping out of these programs? •
	<p>What is the impact of health reform on employer insurance coverage decisions (offer rate, benefit design, deductibles, and premium contribution) and risk of migration from commercial</p>	<p>Perceptions of employers about Catamount Health</p> <ul style="list-style-type: none"> • How do they feel about the assessment? Is it fair? <p>Response of employers to Catamount Health</p> <ul style="list-style-type: none"> • How are businesses responding? 	<ul style="list-style-type: none"> • How do employers feel about the employer assessment? Do they perceive it as “fair”? • What appears to be happening in the private insurance market since the implementation of Catamount Health? • Have determinations of employer coverage (as part of Catamount and ESI eligibility process) shown any trends in terms of benefits employers are offering? • How have employers responded to CH/VHAP? • Has there been an effect on premiums and out-of-pocket costs?

Dimension	Study Questions	Overarching Interview Domains	Interview Questions
	coverage to CH/VHAP?	<ul style="list-style-type: none"> Who is dropping existing coverage? Who is deciding to offer? 	<ul style="list-style-type: none"> What else has been happening in the state since 2005 that may affect affordability and enrollment into public and private insurance?
	What effect do these policies have on the sustainability of community health centers with cost-based reimbursement and enhanced funds available for sliding fee scales for the uninsured?	<p>Changes in FQHCs and FQHC look-alikes due to health reform. (What has happened since implementation of health reform?)</p> <p>Changes in number of people getting care through FQHCs and look-alikes</p> <p>Impact on non-FQHC providers</p>	<p>Bistate Primary Care Assoc/Medical Society/Hospital Association</p> <ul style="list-style-type: none"> What changes to FQHCs and FQHC look-alikes have occurred as a result of the health reform? in terms of payor mix and utilization? Is there any evidence of more people (or fewer) getting care through FQHCs? Has there been any impact of the health reform on demand for non-FQHC providers? What has been the impact on hospital uncompensated care rates? Have providers generally been continuing to accept Catamount or is there evidence that doctors or other health care providers are restricting access to Catamount recipients?
Sustainability	How viable are the funding sources over time?	<p>Funding sources to maintain current and expected levels of enrollment</p> <ul style="list-style-type: none"> Expected viability of funding sources in the future <p>Concerns about sustainability</p> <ul style="list-style-type: none"> What next? <p>Concerns about feds matching premium subsidies only to 200% FPL</p> <ul style="list-style-type: none"> Chances position will be changed One-time money used to plug gap this year. What 	<ul style="list-style-type: none"> How has the program's ability/inability to stay within budget and address consumer affordability during early implementation affected its sustainability? How has the initial program experience (i.e., program costs and/or participation rates) contributed to or eroded policymaker, key stakeholder, and public support for the program? What do you see as a politically viable funding mechanism for the program going forward in light of the current budget deficits? Do you have any concerns about the viability of funding sources in the future? Is there any chance that the feds will change their position on matching to 200% FPL? This year, one-time money was used to plug the gap in funding. What will happen in the future? <p>Year 2 Only</p>

Dimension	Study Questions	Overarching Interview Domains	Interview Questions
		will happen in future?	<ul style="list-style-type: none"> • What is the future for Catamount/Health Reform in Vermont in one year? Five years? 10 years? • How viable are funding sources over time?

XI. APPENDIX 3 – GLOSSARY OF ACRONYMS

Catamount Health without premium assistance (CH)

Catamount Health with premium assistance (CHAP)

University of New England - Center for Health Policy, Planning, and Research (CHPPR)

Centers for Medicaid and Medicare Services (CMS)

Current Population Survey (CPS)

Employee Retirement Income Security Act (ERISA)

Employer Sponsored Insurance (ESI)

ESI premium assistance program for those eligible for Catamount Health (ESIA)

Federal Poverty Level (FPL)

Full Time Equivalents (FTE)

Health Care Affordability Acts (HCAA)

Massachusetts (MA)

Medical Expenditure Panel Survey (MEPS)

Office of Vermont Health Access (OVHA)

Patient Protection and Affordable Care Act (PPACA)

Robert Wood Johnson Foundation's (RWJF)

Vermont Health Access Program (VHAP)

Employer-sponsored insurance for those otherwise eligible for VHAP (VHAP ESI)

Vermont Household Health Information Surveys (VHHIS)

Vermont Health Insurance Plan (VHIP)

Vermont Information Technology Leaders (VITL)

Vermont Public Interest Research Group (VPIRG)

Vermont (VT)