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ACHIEVING UNIVERSAL COVERAGE
THROUGH COMPREHENSIVE
HEALTH REFORM:
THE VERMONT EXPERIENCE

YEAR 1 INTERIM REPORT



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Achieving Universal Coverage Through Comprehensive Health Reform: The Vermont Experience

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I. EXECUTIVE SUMMARY

This report presents the interim results 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) Health services access (especially access to primary health care), 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 first year report includes:

- Findings from interviews with key stakeholders,
- An analysis of affordability using data from the 2005 and 2008 Vermont Household Health Information Surveys (VHHIS),
- Initial findings from enrollment data,
- Baseline data on fringe benefits, and
- Preliminary analyses of sustainability.

In the second year of our evaluation activities, we plan to refine and expand our analyses to incorporate an additional year of data, answer new questions, and improve our analytical methods. We will also examine an area we have not yet explored -- the impact of the reforms on access to care.

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

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that approximately 10% of Vermont's population remained uninsured¹ while *per capita* health care costs were rising faster than the US rate.²

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 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, access to care, program administrative costs, and related measures. Data sets used to conduct the analyses in this first report include:

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

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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Key Findings

As with any significant piece of health reform legislation, there have been challenges with implementation of the 2006 HCAA. However, preliminary data presented in this interim report suggest that since the 2006 HCAA was enacted and implementation began, the percentage of uninsured Vermonters has been reduced significantly, and enrollment in both public insurance programs and private insurance has increased in the state. Key findings include:

- **The percentage of uninsured Vermonters has decreased.** Between 2005 and 2008, 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.
- **Enrollment in the new Catamount Health program increased sharply and steadily during the initial months.** By April 2009, a total of 8,758 people were enrolled in Catamount Health. Most of these enrollees receive premium assistance. Only 13.9% 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 3.1% among those who had always been eligible for public insurance and 3.5% among those who were newly eligible for public coverage. In comparison, coverage rates increased more moderately (1.1%) among those who were never eligible 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 5.5%, while enrollment in VHAP increased by 21.0%. As a result of a variety of outreach activities (e.g., rebranding of the state-funded programs to Green Mountain Care, development of a new website, television and

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print advertising, and training of health care providers, outreach workers, and human resource professionals), nearly half of Vermonters surveyed 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.

- **There have been some barriers to enrollment, but modifications to the reforms have been made to address these barriers.** Although insurance coverage has increased, enrollment for both Catamount and Employer Sponsored Insurance with Premium Assistance did not reach initial projections. 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 4 bills have been passed to date to modify and clarify the original HCAA health reforms and address these barriers. With the anticipated Vermont State budget shortfalls and the planned oversight built into the HCAA, it is expected that there will be additional changes to the reform efforts in the coming years.
- **The program, as currently funded, does not appear to be fiscally 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, state revenues from all sources were approximately \$7.6 million. Since December 2007 the fund balance has declined as program revenues are not keeping pace with expenditures. Unless program expenditure patterns change, new sources of revenues are found or structural changes in the plans occur, the fund balance will be depleted over time. The preliminary information presented here indicates that program fiscal sustainability as a function of premium expenditures versus tax and other revenues is not currently 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.** While acknowledging that there were many unanswered questions at this point regarding the financial feasibility and the ideal mechanisms for financing state health reform efforts, key informants generally expressed hopefulness about the future of Vermont's health care reforms. Most expressed confidence that the Catamount Health Plan and Employer Sponsored Insurance Assistance programs would continue indefinitely into the future. 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. Among other issues, the legislature will

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soon review the costs of the public/private insurance plan design of Catamount Health and whether an individual mandate is needed to reach near-universal insurance coverage in Vermont. Informants are also optimistic that additional support for the programs will be received from the federal government in the future.

Next Steps

In the second year of our evaluation activities, we plan to refine and expand our analyses to incorporate an additional year of data, answer new questions, and improve our analytical methods. We will also examine an area we have not yet explored -- the impact of the reforms on access to care.

In terms of addressing the affordability of Vermont's reform programs, we will further explore enrollment data from OVHA to conduct a churn analysis, examining the rates and reasons for disenrollment from Catamount, as well as an examination of transfer rates from VHAP to VHAP ESI programs to better understand the impact of these programs. We will also use VHHIS 2009 results to analyze take-up rates in Catamount by health status and age, and further explore the impacts of HCAA on health coverage in Vermont. Additional data collection on employer coverage in Vermont since enactment of HCAA will permit for a more thorough analysis of crowd-out and out-of-pocket health care costs in the context of reform.

In year 2 of the evaluation we plan to further explore sustainability issues as well. For example, we plan to obtain claims data on program enrollees—this will assist us in determining the actual costs of the program to both the state and insurers. It may also permit us to assess the health status of program enrollees and their patterns of care over time. We expect to be able to calculate and trend member per month costs against revenues. This will provide a more accurate picture of program sustainability and in turn permit a more informed policy discussion of mechanisms to address sustainability.

Despite the limitations of this interim presentation of findings, this report offers important perspectives on the formation, passage and experience to date of Vermont's health reform legislation. It also includes preliminary analyses of enrollment, affordability, and sustainability of Vermont's new health coverage programs. This information, while not conclusive after less than 2 years of program implementation, provides valuable insights to inform future reform efforts in Vermont and in other states experimenting with health care reform legislation. Overall, Vermont's reform package looks promising as a vehicle to provide access to care for a population that had no insurance prior to the implementation of this legislation.

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II. INTRODUCTION

This report presents the results of the first year 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 three key dimensions of Vermont's comprehensive health reform:

- Health coverage affordability,
- Health services access (especially access to primary health care), and
- Sustainability of the reform.

During the first year of our evaluation, our main focus was the process 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 first 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 and 2008 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. The methods we have developed for this affordability analysis will be refined in the second year and adapted to utilize 2009 VHHIS data. In the first year, we also begin to examine baseline data on fringe benefits in Vermont to explore employer coverage and use State revenue and expenditure data to make some preliminary predictions regarding sustainability of new programs.

As with many evaluations, the first year has been a year of exploration. While we have answered some questions, many more have arisen. In the second year, we plan to refine and expand our analyses to incorporate an additional year of data, answer new questions, and improve our analytical methods. We will re-interview many of our key stakeholders to learn what has happened as the year progressed, what new issues have arisen, and how perceptions have changed. In the second year, we will also examine an area we have not yet explored -- the impact of the reforms on access to care.

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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, regardless of other insurance status, using Medicaid and CHIP funds.

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 Governor 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 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 over 20,000 people. Initial funding came solely from an increase in the state cigarette tax, but funding was ultimately integrated into the broader Medicaid program. The 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-roots, broad-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 for, and were included verbatim, in both the vetoed 2005 bill and the successful HCAA of 2006.

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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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 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 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 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 health care 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 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

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.

⁸ Douglas 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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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 with using federal waivers to provide flexibility for its Medicaid expansion programs. In 1995, Vermont was granted a Section 1115(a) waiver to extend coverage under the VHAP program. Federal Medicaid waivers, authorized through the Social Security Act, allow states to expand health coverage programs beyond the traditional income limits set for Medicaid populations, provide services that are not typically covered, or use innovative service delivery systems while maintaining a federal match from the Centers for Medicaid and Medicare Services (CMS) to 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 as a managed care organization whereby they would be paid a premium for each Medicaid program enrollee to ensure provision of all Medicaid services in the state.

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. As such, 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. Nevertheless, the Waiver was an essential component of Vermont's health reform, even if it failed to meet the full expectations for federal funding support.

2006 Legislative Session

During the 2006 Legislative Session, a change took place with respect to health reform. 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 choose to wait for a new administration or to 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 implications of

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

A private consultant, 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 will evaluate costs and enrollment to see if the privately run program was more or less cost-effective than a publicly run program would have been.

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.

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>

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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 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. These estimates proved to be both similar and overstated.

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.

DESCRIPTION OF NEW PROGRAMS

2006 HCAA

The 2006 HCAA had three primary goals:

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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 a "traditional" insurance product with specific benefits that any Vermonter 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.

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 with a \$250 deductible and \$800 out of pocket maximum. 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). 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). The state was able to secure lower premium costs compared to equivalent benefit plans on the private 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 \$393 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.

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

Income (as % FPL)	Cost per person to enroll in Catamount Health
Up to 175%	\$60
175-200%	\$65
200-225%	\$110
226-250%	\$135
251-275%	\$160
276-300%	\$185
Over 300%	Full price (currently \$393 per month for single coverage)

The state subsidizes the difference in premiums between full cost enrollment and the fee paid by the enrollee. Premiums for those receiving premium assistance have increased once since implementation of the program, not as a result of the carriers raising premiums, because the legislature raised the premiums in 2008 to help make the program sustainable. Simultaneously, a \$400 earned income disregard was put into place in 2008 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. 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. However, the income disregard is still intact.

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 cheaper to do so than to pay for VHAP or Catamount Health. This is intended to shift some of the costs of Catamount Health and VHAP to employers.

- 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 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.

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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.¹² The Blueprint is currently in the pilot stage. 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.¹³ 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. 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 new Catamount enrollees and Vermonters enrolled in Medicaid, Dr. Dynasaur and VHAP.

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, 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. As a result, the State had to allocate additional general fund revenues to make up the difference. There is a provision in the legislation that enables the state Emergency Board¹⁴ 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

¹² Conis, Elena. "Vermont's Blueprint Chronic Care Initiative". *Health Policy Monitor*, November 2008. Available at <http://www.hpm.org/survey/us/a12/1>

¹³ Vermont Blueprint for Health, 2007 Annual Report, produced by Vermont Department of Health, Agency of Administration, January, 2008. Available at: <http://healthvermont.gov/prevent/blueprint/documents/BlueprintAnnualReport0208.pdf>

¹⁴ The Emergency Board includes the Governor and the four chairs of legislative money committees

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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. If health care spending in Vermont had grown at projected rates, the money might not have been adequate. 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. 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. Without innovative programs such as these, it would have been difficult for Vermont to stay under the Global Commitment Waiver cap.

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 or offered and not covered by insurance. 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 is based on the number of full time equivalents who are not offered insurance or who are offered insurance but choose not to enroll (and remain uninsured). The assessment, which began on July 1, 2007, is \$91.25 per quarter (\$365 per year) per full time equivalent. To ease the burden on employers, 8 full time equivalents (FTEs) were exempt from the assessment in fiscal years 2007 and 2008. This exemption is set to drop 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 will increase at the same rate as premium increases to the Catamount Health plan as defined by the private carriers.

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 legislature will re-evaluate whether a health insurance mandate on individuals is needed to achieve universal coverage.
- *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. Dynasaur premiums.* Due to concerns about affordability, premiums for children enrolled in the Dr. Dynasaur 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

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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 populations¹⁵. 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 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, four additional bills have been developed and passed to modify the 2006 bills. These are worth mentioning because they 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 HCAA ¹⁶
Act 70 of 2007 <i>An Act Relating to Corrections and Clarifications to the Health Care Affordability Act of 2006 and Related Legislation</i>	<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

¹⁵ Other than age-rating in the individual market by for-profit insurers

¹⁶ 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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	<p>electronic health record systems.</p> <ul style="list-style-type: none"> • 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 for primary care health services, mental health care providers, and other non-physician health care providers.
<p>Act 203 of 2008 <i>An Act Relating to Health Care Reform</i></p>	<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.
<p>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></p>	<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.

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REFORM PROGRAMS IN OTHER STATES WILL CONTINUE TO INFORM VERMONT

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. In this section, we briefly describe a few of these key issues in which outcomes in other states, particularly Massachusetts, will be valuable.

Individual Mandates

One key issue that Vermont policymakers will face in the near future is the issue of individual mandates. As discussed previously, the 2006 HCAA included a provision that requires the legislature to re-evaluate whether a health insurance mandate on individuals is needed if less than 96% of Vermont's population is insured by 2010. Current estimates of insurance coverage in Vermont show that the state, while making progress, is still far from this 96% goal. It appears likely that the 96% goal will not be achieved by 2010, so this issue will be brought before the legislature.

A study by Chernew et al. showed that voluntary programs may never achieve universal coverage because some will choose not to enroll for reasons unrelated to premium cost and that, even when insurance was fully subsidized, some workers did not enroll.¹⁷ If this holds true in Vermont, even given the aggressive outreach that the state has conducted to de-stigmatize state insurance programs, we can expect that the state will have difficulty reaching its 96% goal, given the voluntary structure of Vermont's programs.

Vermont will look to Massachusetts for insight as the state explores the individual mandate issue. Massachusetts enacted an individual mandate that began on July 1, 2007. As of that date, Massachusetts residents age 18 and older were required to have health insurance that was deemed affordable to them at their income level or they risk being penalized on their personal state income taxes. The fine in 2007 was the loss of a personal exemption (estimated at \$200). For 2008 and beyond, those not in compliance may be assessed a fine that is half the cost of the lowest-cost yearly health care plan deemed available to them at their income level. In 2009, the fine for those over age 26 with incomes greater than 300% FPL was \$1,068. In comparison, those with incomes 150-200% FPL incurred a fine of \$204 per year if not insured. Under the mandate (and other provisions of the Massachusetts reforms), approximately 97% of Massachusetts residents are insured and coverage has been expanded to two thirds of those who were previously uninsured.

¹⁷ Chernew, Michael et al. The Demand for Health Insurance Coverage by Low Income Workers: Can Reduced Premiums Achieve Full Coverage? [Health Services Research](#) 32:4 (Oct. 1997) 453-470.

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Although the Massachusetts experiment with individual mandates is still young, it is already providing some important lessons. First, individual mandates *do* appear to provide an incentive for individuals to enroll in health insurance, as evidenced by the very low percentage of uninsured in the state. Unfortunately, achieving this goal was costly. Initial projections had set the cost for 2008 at \$472 million; however, the actual cost was closer to \$717 million, and costs were even higher in 2009 and may have exceeded \$1 billion.¹⁸ Although Massachusetts has targeted a specific health plan to young, healthy individuals, many of the still uninsured are younger individuals that the state sought to bring into the program to help bring down the costs of premiums for all. One lesson Vermont may take from the Massachusetts experience is that achieving high levels of coverage may not be fiscally sustainable for a state like Vermont that is generally less wealthy than Massachusetts. Any use of an individual mandate will need to be coupled with cost containment efforts. In addition, the Massachusetts case shows that the young, healthy population will still be challenging to reach, even with a mandate.

Employer Mandates

Employer mandates are another critical issue in health reform. Vermont's employer assessment is essentially a mandate that shifts some of the costs of health reform to employers who do not provide insurance for their employees. However, the assessment in Vermont (\$365 per year per full time equivalent), is low in comparison to the cost of insuring workers. Thus, it may not actually incentivize employers to provide insurance to their employees.

In the future, Vermont will have to decide whether to keep the employer assessment at current levels, lower the assessment, or increase the assessment. It may draw upon the experiences of other states who have experimented with such assessments. Between 1988 and 1993, Massachusetts, Oregon, California and Washington passed employer "pay or play" mandates, but each lost political and economic support before implementation.^{19,20} Since 1972, Hawaii has mandated that certain employers purchase health insurance for their employees but Hawaii is able to do this only because it has a statutory exemption from the Employee Retirement Income Security Act (ERISA). Increases in insurance coverage have been modest and employment has shifted toward sectors not subject to the mandate.²¹ The success of insurance mandates may depend on the cost of compliance, the penalties for noncompliance, and the timely enforcement of compliance.²²

¹⁸ Smulowitz, PB. A Model for Expanding Health Insurance? Lessons Learned from the Massachusetts Experiment. ACEP State Legislative/Regulatory Committee. January 2009.

www.acep.org/WorkArea/DownloadAsset.aspx?id=45176. Accessed May 31, 2009.

¹⁹ Oberlander, J. Health Reform Interrupted: The Unraveling Of The Oregon Health Plan, *Health Affairs*, 26, no. 1 (2007): w96-w105

²⁰ California Health Care Foundation. State Employer Health Insurance Mandates: A Brief History. March 2004. <http://www.chcf.org/documents/EmployerInsuranceMandates.pdf> Accessed June 2, 2009.

²¹ N.K. Thurston, "Labor Market Effects of Hawaii's Mandatory Employer-Provided Health Insurance," *Industrial and Labor Relations Review* 5, no. 1 (1997): 117-135.

²² Glied SA, Hartz J, Giorgi G. Consider it done? The likely efficacy of mandates for health insurance. *Health Aff (Millwood)*. 2007 Nov-Dec;26(6):1612-21.

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Massachusetts' 2006 health care reform law has employer provisions similar to that enacted by Vermont. In Massachusetts, any employer that does not make a "fair and reasonable" premium contribution to an employer-sponsored health insurance plan is liable for a penalty of up to \$295 per employee. There are exemptions for employers who have a percentage of their employees enrolled in a plan or who make a contribution to premium costs. A 2008 survey of Massachusetts firms indicated that most firms view reform as "good for Massachusetts" and that the percentage of firms with three or more workers offering coverage increased from 73 percent to 79 percent.²³ Even with the low penalties in Massachusetts and availability of new state programs, the survey found little evidence of "crowd-out" or firms dropping coverage and shifting their employees to state programs. However, small firms appeared to know little about the state insurance programs.

In our interviews conducted for this evaluation report, we had difficulty engaging the business community to gauge the perceptions of employers with respect to the mandate. However, informants familiar with the Vermont business community have indicated that there was little resistance to the employer assessment, perhaps because, like Massachusetts businesses, many Vermont firms perceive the assessment as a positive thing for the state. While the employer mandate issue will be touched upon in this year's evaluation report, we hope to present additional analysis of Vermont's assessment, including perceptions of the assessment among the business community and the impact of the assessment on employer offer rates, in the 2010 evaluation report. We will also keep a close eye on findings from Massachusetts on this issue.

Strategies to Control Costs

As described in the above section on Individual Mandates, without cost containment measures, expanding access to insurance will not be fiscally sustainable. 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^{24, 25} and high cost sharing for low-income beneficiaries.²⁶

Another key measure for cost containment in Vermont is the Blueprint for Health chronic care management program. Blueprint for Health programs are expected to control

²³ Gabel JR, Whitmore, H, Pickreign J, Sellheim W, Shoya KC, Bassett, V. After The Mandates: Massachusetts Employers Continue To Support Health Reform As More Firms Offer Coverage. *Health Affairs*, 27, no. 6 (2008): w566-w575

²⁴ 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).

²⁵ Blumberg, Linda J. *Increasing Health Insurance Coverage of Workers in Small Firms: Challenges and Strategies*. Urban Institute Report (2007).

²⁶ Kaiser Commission on Medicaid and the Uninsured. *Serving Low-Income Families through Premium Assistance: A Look at Recent State Activity*. (2003).

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escalating health care costs through community centered programs, 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 and may be difficult to measure accurately.

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.²⁷ 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.

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

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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.

A description of the planned research strategies are outlined below. This first year report contains a focus on process evaluation questions and some preliminary analyses of datasets that will be used in the evaluation. For some analyses that have been planned, however, data sets will not be available until the final evaluation report (Year 2). Additionally, in some cases, the findings in this initial report pose additional questions that warrant further exploration. We will attempt to address those questions in the final evaluation report.

EVALUATION GRID

Table 2 presents the research questions for this evaluation, the data sources that will be used to answer these questions, and the associated analyses.

Table 3: Evaluation Questions and Data Sources

Dimension	Questions	Data	Analyses	Report Year
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>	<ul style="list-style-type: none"> • Stakeholder interviews • Publications and Historical Documents 	<ul style="list-style-type: none"> • Summaries of stakeholder interviews • Analysis of content for key themes and lessons learned 	Year 1 Updated in Year 2
Affordability of Health Insurance and Enrollment	Do the trends in health insurance coverage for Vermonters indicate an increase in public coverage?	<ul style="list-style-type: none"> • VT Household Health Insurance Survey (2005, 2008, 2009) • CPS Insurance 	<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 	Year 1 Updated in Year 2

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	<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 pool of people who would 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>	<p>Coverage Estimates (2005, 2008)</p> <ul style="list-style-type: none"> • Administrative data on enrollment 	<p>2005 vs. number actually eligible in 2008/9</p> <ul style="list-style-type: none"> • 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 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>	<ul style="list-style-type: none"> • VT Fringe Benefit Survey (2005, 2007, 2009) • Kaiser Foundation's employer health benefit survey (2005, 2007, 2008) • Medical Expenditure Panel Survey (2006, 2007) 	<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>Year 2</p>
	<p>How have the health reforms impacted premiums and out-of-pocket costs?</p>	<ul style="list-style-type: none"> • VT Household Health Insurance Survey (2005, 2008, 2009) • Fringe Benefit Survey (2005, 2007, 2009) • Kaiser Foundation's employer health benefit 	<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 	<p>Year 2</p>

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		<ul style="list-style-type: none"> survey (2005, 2007, 2008) Medical Expenditure Panel Survey (2006, 2007) 		
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>	<ul style="list-style-type: none"> DOH (changes in the number of FQHC look-alikes and use of sliding fee scales) OVHA Medicaid data on rate changes and utilization HRSA Uniform Data Set (UDS) data on VT FQHC payor mix (2006, 2007, 2008) 	<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 	Year 2
	<p>What effect do the policies have on the size of the population with a usual source of care?</p>	<ul style="list-style-type: none"> VT Household Health Insurance Survey (2005, 2008, 2009) 	<ul style="list-style-type: none"> Trends in number and characteristics of population without a usual source of care 	Year 2
	<p>What effect do the policies have on ER use by patients diagnosed with ambulatory care sensitive conditions?</p>	<ul style="list-style-type: none"> ER use data (BISCHA) (2006, 2007, 2008) 	<ul style="list-style-type: none"> Trends in ER use among patients with ambulatory care sensitive conditions 	Year 2
Sustainability	<p>How viable are the funding sources over time?</p> <p>Are expenditures likely to exceed revenues over time?</p>	<ul style="list-style-type: none"> Program expenditure data (BISCHA) Revenue data (VT) Expenditure and claims data (OVHA) 	<ul style="list-style-type: none"> Revenue projections from each source Expenditure projections for each program 	Year 1 Updated in Year 2

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 and early 2009. We interviewed a variety of stakeholders, including representatives from Vermont's legislature, representatives in the Douglas administration who are responsible

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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, to future directions. Many similar themes were described by different informants.

With help from Dr. Susan Besio, Director of the Office of Vermont Health Access, we generated a list of key stakeholders. Working with researchers from University of Southern Maine's Muskie School who were planning to interview similar stakeholders for their multi-state evaluation of state health reform (also funded by RWJF), 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 total, we conducted 3 days of in-person interviews in Vermont and spoke with people 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. The complete list of interviewees 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 and Blueprint for Health 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.

Affordability of Health Insurance and Enrollment

To begin to address the research question: *How affordable are Vermont's insurance plans across demographic, socioeconomic and geographic groupings?* this evaluation will be using data from several sources to look at affordability 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, and CPS health coverage data for New England and the United States as comparisons.

The first question we will address is whether the insurance plans are affordable as measured by enrollment of the uninsured into Catamount across demographic,

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socioeconomic and geographic 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 to look for 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.²⁸

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 look at the impact of each of these factors, we use VHHIS data to estimate the segment of the Vermont population in 2008 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. 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 it now looks as though the State may not collect data in 2009 due to financial constraints.

²⁸ We use the 2005-2008 within state comparison (difference) and the 2005-2008 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 and 2008 surveys and in the comparison state surveys and compare outcomes across these multidimensional groups.

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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 – this year’s report presents some data from the 2006 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. For this Year 1 report, the 2006 MEPS data serves as a baseline for Vermont, as the survey was conducted prior to the implementation of Vermont’s HCAA.

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. In the final evaluation report (Year 2), we will further explore this data and available Vermont Fringe Benefit Survey data. 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. In the Year 2 report, through further data and process evaluation, we hope to get a better idea of 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 attributable to crowd-out.

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. A 2007 report by the Legislature recommends that new sources of state funding will be required to continue health reform efforts in the future; the Legislature is expected to address this recommendation at subsequent sessions.

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

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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 up to 200% in Vermont's 1115 waiver, with the expectation that CMS policy will change within the next few years. Our evaluation will assess the viability of the revenue streams, including the potential for cost savings from the ESI premium assistance program to cover expense requirements of expanded insurance coverage.²⁹

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 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.³⁰

²⁹ The financial impact of the premium assistance component of the ESI program—its impact on the health insurance offering rate and private insurance benefit design/coverage compared to CH and the VHAP is not addressed in this report. It will be addressed in year 2 and we plan to include an estimate of substitution effects (cost savings) from use of ESI premium assistance rather than CH or VHAP.

³⁰ Evaluating the contribution of the Vermont Blueprint in sustaining health reform by reducing demand for higher cost services will be completed in year 2 of the evaluation. Emergency room and hospital discharge rates for specific conditions (i.e. diabetes) from similar communities (Blueprint and non-Blueprint) will be trended over time to assess the potential impact of the Blueprint on these high cost services.

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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.³¹

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 in the months since the revision. 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, and why actual enrollment was lower than those initial projections.

Although the original enrollment projections used available data and statistical modeling, many informants expressed that it would have been impossible to accurately predict

³¹ "Awareness of Green Mountain Care: Results from a Statewide Survey of Vermonters", Lake Research Partners, presented February 6, 2008.

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enrollment given the unknowns involved in these calculations. Most interviewees also expressed satisfaction with existing enrollment levels.

Future research into enrollment will need to include focus groups with applicants and enrollees to determine their perspective on the multi-step processes involved. The collection of information on the reasons for disenrollment, which is being gathered only in the aggregate at present (i.e. for all Green Mountain Care programs), could provide valuable insight into enrollees that drop out of the program. Maximus, the contractor hired by the State to handle the 1-800 hotline for state health care programs, reports on disenrollment from all State programs monthly. This data shows that the most frequently cited reason for disenrollment from any publicly funded health care program is loss of eligibility, presumably based on changes in household income. Further analysis of these trends, including a separate analysis for Catamount and Catamount ESIA disenrollments, will likely add to our understanding of the factors contributing to Vermonters losing coverage from these new programs. However, most agree that despite the fact that original projections were high, actual enrollment has been successful and has led to more Vermonters with health insurance coverage, despite the current economic environment.

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 almost \$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. In the second year report, we will explore this issue further. 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. One issue that should be explored in future reports is the impact of the VHAP and Dr. Dynasaur premium reductions passed in the 2006 HCAA and whether premium reductions resulted in enrollment increases for these programs.

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

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because they have not been able to afford comprehensive coverage (the underinsured³²), 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 to sign up for Catamount without waiting for 12 months. Although Act 203 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 \$10,000. These individuals could be considered underinsured because they cannot access primary care and preventive services without substantial out of pocket cost. However, they do not qualify for the waiting period exemption.
- Those with a \$10,000 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 progress has been made on this front.

Some who we interviewed expressed a desire to change the 12-month waiting period to 6 months to address this barrier to enrollment. However, in order to change the 12 month waiting period, federal approval would have to be achieved. Act 203 passed in 2008 responded to this complaint and provided a provision whereby the Secretary of Human Services must apply for permission from the federal government to change Catamount Health's waiting period from 12 months to 6 months no later than February 1st, 2009. The state has applied for this amendment, but CMS has not made a decision yet. If such approval is received, the Commission on Health Care Reform would be charged with analyzing the impacts of such a change to enrollment and financing and subsequently making a recommendation to the legislature on whether the waiting period should be reduced. It is unclear at this point what the outcome of this process will be.

³² Although researchers, including the Commonwealth Fund and others, have recently been working to create a quantifiable, common definition of underinsurance, in this Year 1 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. In the Year 2 analysis we hope to further explore the issue of underinsurance using VHHIS and CPS data, which will require that we will select and report an explicit and quantifiable definition for this term that is appropriate for Vermont.

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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 requires 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.
- 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 State of Vermont has plans to revise 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 anytime soon.

One other barrier that should be noted affects ESIA. Employer sponsored insurance has to be comparable to Catamount for Vermonters to receive premium assistance through ESI. This comparability issue has kept ESIA enrollment down because Catamount Health has a very rich benefit plan and low deductible, and most employer plans do not compare. As a result, most employees are not eligible for ESIA and must enroll in Catamount Health instead, keeping the ESIA enrollment low. 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.

There are also indications that many who enroll in the Green Mountain Care programs often drop coverage periodically and re-enroll later. This disenrollment is not currently being adequately monitored. Although there are indications that between 1 and 2% disenroll each month and that most re-enroll within 3 months, we do not know exactly who drops coverage and why this periodic disenrollment occurs.

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 Global Commitment Waiver. It was highly anticipated that CMS would allow federal matching up to 300% FPL based on Massachusetts securing this approval in their 1115 waiver for comprehensive health care reform. However, CMS only granted a match up to 200%

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FPL which meant that Vermont has had to contribute a greater amount of state resources to enact Catamount than was originally projected. The State is hopeful that with the new democratic administration in power at the federal level, CMS will approve federal matching for Catamount recipients up to 300% FPL via a waiver amendment request that was submitted in Spring, 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 of sorts. 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, four 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 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 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 one year, from the start of the program, in which 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.

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- 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.
- 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 anticipated Vermont State budget shortfalls and the planned oversight built into the HCAA, 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 financial feasibility and the ideal mechanisms for financing state health reform efforts.

Regarding the financial prospects for the health reforms in Vermont, informants predicted future opportunities as well as challenges. 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. 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 changes yet 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 be 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.

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There are also questions to be answered about the future financing of Catamount and the other health reforms. Specifically, the question of whether health care costs will outpace revenue sources for health reform in Vermont remains unanswered. 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 decrease and prevent tobacco use. These financing questions will become more relevant if the two Catamount health insurance companies, Blue Cross Blue Shield and MVP, increase premiums for Catamount in the upcoming year as many anticipate they will.

As mentioned previously, another big unknown regarding the sustainability of the health reform relates to the likelihood of amending the Global Commitment Waiver to allow for federal matching for recipients with incomes between 200 and 300% of the federal poverty level. Many are optimistic about this given the new Obama administration and the passage of the recent SCHIP reforms by Congress. However, there are no guarantees that this will occur, especially given the current federal deficit and challenging economic times. It is not clear whether Catamount Health Plan will remain financially supportable without this increase in federal matching.

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 as evidenced by the latest VHHIS results, described later in this report. The Health Information Technology Trust Fund has been put in place and there are plans to implement electronic medical records for independent primary care physicians throughout the state with this fund. The Blueprint for Health pilots have been a success according to those involved and these efforts are expected to continue and spread in the coming years. So while the future remains an unknown in terms of federal matching and other revenue sources, 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.

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.

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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 four 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.

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.

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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 is currently using 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, it is widely acknowledged that this level of state funding will only be sustainable in the short term. Vermont is counting on a renegotiation of this in the next Waiver renewal process to continue offering subsidies for individuals and families at this income level. 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.

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 new and existing programs, this website only provided a screening tool to determine eligibility for these programs. The actual enrollment process for Catamount initially involved application to 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 and 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 at this early stage in their reforms 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. While these changes will likely occur slowly and require sustained effort and commitment on behalf of decision makers, providers, and the general public, they provide a roadmap for driving overall healthcare system reform which has the potential to remain in place regardless of federal health care reform or ongoing state efforts to increase the insured population. The Blueprint reforms increase the chance that

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Vermont will end up with a more cost effective and high quality health care system, regardless of future health insurance reforms.

WHAT ARE THE NEXT STEPS TO REFORM? WHAT ARE THE BARRIERS?

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. 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. This section will describe some of the structural and financial changes to the programs that are being suggested by various advocates in Vermont and some of the anticipated future barriers to program sustainability and expansion Vermonters are concerned about.

Potential Changes to Structure of Health Reform Programs

As noted earlier in this report, the decision to create a publicly-subsidized but privately-offered insurance plan to expand access for the uninsured was the result of compromise between the legislature, which had previously proposed a publicly funded and operated health plan, and the Governor, who was unwilling to consider an option that did not involve private insurance participation. Although the resulting Catamount Health Plan is a public/private hybrid, there was oversight built into the HCAA legislation mandating a thorough review of the relative costs, including administrative costs, of this model as compared to a publicly funded and managed program no less than 2 years from the initiation of the program. This review is anticipated to get underway in October 2009 and there is already much speculation about the implications of this study which has the potential to provide information of national significance regarding the feasibility and sustainability of public/private partnerships in expanding access to care. The results remain to be seen, but clearly Vermont will have to make a decision in the coming year about whether to continue with Catamount in its current structure or whether to convert the program to a public insurance product.

Another big picture question regarding Catamount is around mandates. It may be difficult or impossible to achieve Vermont's goal of 96% coverage without mandating that individuals must have some sort of coverage or pay penalties. In 2006, Vermont opted not to impose an individual mandate, while Massachusetts has imposed such a mandate. Given that these two states have implemented two of the most comprehensive health coverage reform programs in the nation to date, they provide an opportunity to contrast the results with or without such individual mandates. Some believe that the goal of 96% coverage cannot be achieved as long as the relatively healthy and young can opt out of coverage because some individuals will not purchase insurance, even if it is affordable and offered at relatively low cost. Others believe that if you make the programs affordable enough for everyone mandates are not necessary, and can in fact be harmful by penalizing those who cannot afford health insurance either because they do not qualify for subsidies or because the subsidies are inadequate. This question will

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continue to be raised until Vermont achieves 96% coverage, if it can achieve this near-universal level of coverage among its residents.

In addition to these big picture structural issues that will be debated over the years to come, there are also some smaller modifications being proposed for Catamount Health in the near term. One concept that was proposed by the Governor's office during the most recent legislative session was to create a so-called "Catamount Lite" which would essentially be a pared down version of the current benefits with a high deductible and accompanying health savings account. This product, which may be particularly appealing to younger Vermonters, could be offered at substantially reduced premiums because participants would assume a much greater proportion of cost sharing for their health care. The Governor formally proposed creation of such a product in his Fiscal Year 2010 Budget Address on January 22, 2009.³³ However, this proposal was not passed by the legislature due to the concern that a "Catamount Lite" plan deviates from the state's initial commitment to providing comprehensive, affordable health care that stresses prevention and cost control.

Other proposed changes to the existing Catamount program suggested by informants include:

- changing the 12-month waiting period for those with existing insurance to 6 months,
- increasing the wrap-around coverage for Catamount eligible ESI participants beyond disease management services to cover all services in Catamount that are not covered by the Employer Sponsored Insurance being subsidized (like the VHAP ESI program's wraparound benefits), and
- removing the inclusion of parental income for those ages 18 to 21 in eligibility determination.

All of these proposed changes are expected have the effect of increasing enrollment in the program and/or increasing overall costs to the State for these programs. Due to the existing budgetary constraints in Vermont, it seems unlikely that these changes will occur in the near term, despite advocates desire to see these programs expand and improve access.

Potential Changes to Costs and Financing of Health Reform Programs

Although there are health care cost containment initiatives contained in the Blueprint for Health, most of those we spoke to believe that health care costs will continue to rise in Vermont, at least in the foreseeable future. Similarly, there appears to be a general consensus that the increase in the costs for health care reform activities will outpace any revenues generated from the tobacco tax or employer assessments as they are currently structured.

Another cost-related issue is the cost to consumers for the Catamount Health product. Many of the informants predicted that premiums for Catamount will likely be increased

³³ Available at http://governor.vermont.gov/speeches/Budget_Address_FY2010.pdf

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this year by the insurance companies. During the first 18 months of operation, neither of the two private carriers (Blue Cross Blue Shield and MVP) raised Catamount premium rates. It is unclear whether this was due to claim costs remaining within projected levels or if it was simply a result of the companies having too few months of enrollment to determine any needed adjustments. Competition between the two plans probably also played a role. Premium increases in the future are likely, however, and will make it more difficult for consumers to afford the plans. If the state tries to offset the premium increases for those currently receiving assistance, it will increase the costs to the state. The reality of rising health care costs in general, and the likelihood of increased premiums for Catamount in particular, may necessitate changes in either the financing mechanisms for health reform or cost sharing on the part of participants in the programs.

It appears that, as health costs increase and premium costs rise, the state will walk a fine line between 1) keeping premium costs at an “affordable” level for Vermonters so that current participants will not drop coverage and additional residents will join and 2) maintaining financial sustainability of the programs. As mentioned in the previous section, the Governor has proposed offering a high deductible Catamount plan, or “Catamount Lite” to improve the enrollment among healthy individuals who are unwilling to pay the current premium costs for the Catamount plan. If premiums rise, this may be a way to not only insure more people but also keep people from dropping insurance entirely as premiums rise. However, this will take the state away from its commitment to comprehensive coverage.

The other variable that will likely impact whether Vermont will need to increase cost sharing on behalf of participants is the renewal of the Global Commitment Waiver in 2010 and the likelihood of successfully receiving federal matching funds for those between 200 and 300% of the federal poverty level. If this relief is granted by the federal government, the state will be better able to keep the program sustainable.

Unanswered Questions

It is clear that Vermont’s health care reform efforts will evolve in upcoming years, but it is not clear yet what modifications or additions will occur. Many questions remain unanswered regarding the future of health care reform in Vermont, and key informants posed some thought-provoking questions regarding the direction of health reform in Vermont and in the nation as a whole. It is worth presenting these unanswered questions here.

- *Effect of Lower Reimbursement for Catamount:* Provider reimbursement for seeing Catamount patients is generally lower than it would be for those with typical private insurance plans. This is one of the ways that state is able to offer affordable premiums for Catamount Health. The reimbursement rates were amenable to the medical community because it was expected that those insured by Catamount would otherwise be uninsured. Thus, by getting them to enroll in Catamount, the magnitude of the uncompensated care pool would be reduced. At present, however, a significant reduction in the magnitude of the uncompensated care pool has not been observed, and any reductions would not necessarily affect

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the primary care provider community. There have not been reports of the provider community to date denying access to patients due to this reduced reimbursement schedule. However, it remains to be seen whether providers will continue accepting Catamount patients into their practices should enrollment in Catamount plans increase greatly.

- *Small Businesses, the Self-Employed and the Underinsured:* Many small businesses, which purchase insurance in the small group market, have expressed interest in being included in Catamount Health. At present, there is not a specific program for small businesses, and, in cases where businesses who currently offer insurance would want to pay for their employees premiums to enroll in Catamount, their employees are ineligible due to existing insurance coverage. Even if the employer's coverage is not comprehensive, they still cannot enroll without enduring the 12-month waiting period. This waiting period also affects the self-employed and other individuals who purchase insurance themselves. Many do not want drop existing coverage for a year just to qualify. Some we spoke to wondered whether there might be future reform efforts that specifically target small businesses, the self-employed, and others who are underinsured, and if not, would these populations become disillusioned with reforms that don't seem to include them. With current economic strains, however, it is difficult to see how Catamount Health could be expanded to additional groups in the near future.
- *Sustainability:* One of the biggest unanswered questions for most key informants we spoke to is whether health care reforms enacted in 2006 will be financially viable through 2010 and beyond. The answers to these questions are still unknown, but by examining current trends in coverage in Vermont as well as expenditures and revenues to date for Catamount and ESI programs we can present an informed speculation about the likelihood of Vermont achieving its goals in a sustainable way. The next sections will examine the information we have to date on these topics to shed some light on the impact of the HCAA on Vermont's coverage rates and financial bottom line.
- *Affordability:* Another key question for Vermont and other states struggling with health care reform is the level at which premiums must be set so that they are perceived as affordable. We are still learning what the right premium price point is and whether affordability is different for different populations. The next sections attempt to shed light on the affordability issue.
- *Federal Initiatives:* In terms of national reform, many wonder what initiatives the federal government will be passing in the next few years. Will comprehensive reform occur at the federal level? Or will the federal government pass new incentives for states to address the issue on their own? Will states be expected to take the lead? What will be the implications of federal actions for Catamount and for Vermont's health reform efforts as a whole? These big picture changes are outside the control of Vermont legislators or administration, but these unknown factors could have an enormous impact on Vermont's reforms should any changes occur at the national level.

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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 three years have increased enrollment in state-funded or state-sponsored programs in two different ways:

- The creation of a new program, Catamount Health,
- Increased promotion of existing programs and rebranding of programs.

In addition, as part of reform efforts, the state created a new coverage type in its existing Vermont Health Access Plan (VHAP). Under this option, individuals who were currently covered under VHAP or who applied for VHAP and had access to adequate employer-sponsored health insurance (ESI) would be enrolled in the ESI plan, rather than VHAP. Beneficiary premiums would be the same, with the state covering the difference between the beneficiary premium and the employee share of ESI.

Note that this initiative did not change eligibility requirements for this program, and will be included as part of VHAP in any analyses in this section, rather than as an expansion.

This section describes enrollment in the state health insurance programs as an indicator of affordability of the programs 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 Office of Vermont Health Access (OVHA) issues a report that includes monthly enrollment information for CHAP, CH, ESIA, and VHAP-ESI.³⁴ 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

³⁴ For context, enrollment information is also provided for VHAP, Dr. Dynasaur, and other Medicaid.

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month in earned income to recognize the costs of working. There is also a disregard of the net costs of child care, up to \$175 per child per month.³⁵ The income used for determining eligibility is net of these disregards, while information about the eligible population from the VHHIS is gross income. Efforts are being made to estimate net income to allow for estimation of income-specific take-up rates, but this is proving to be very difficult.

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, was discussed earlier in this report. This disregard 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 are the lack of inclusion of retroactive changes and the lack of information to decompose changes 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 looking at enrollment trends in Medicaid and VHAP for the 18-month period between initiation of the program (November, 2007) and April 2009. Enrollment trends for these programs, as well as the other Green Mountain Care programs, are presented in Figure 1. During this time, there were significant levels of new enrollment:

- Enrollment in traditional Medicaid (excluding VHAP) increased by about 5.5%, from 93,130 to 98,266 (5,136 people).
- Enrollment in VHAP (including VHAP ESI) increased much more rapidly (21.0%), from 24,884 to 31,016. This includes 952 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 35% of new public program enrollees enrolled in this program, while only 25% enrolled in Medicaid (45% enrolled in the new Catamount programs: CHAP, ESIA, and unsubsidized Catamount).

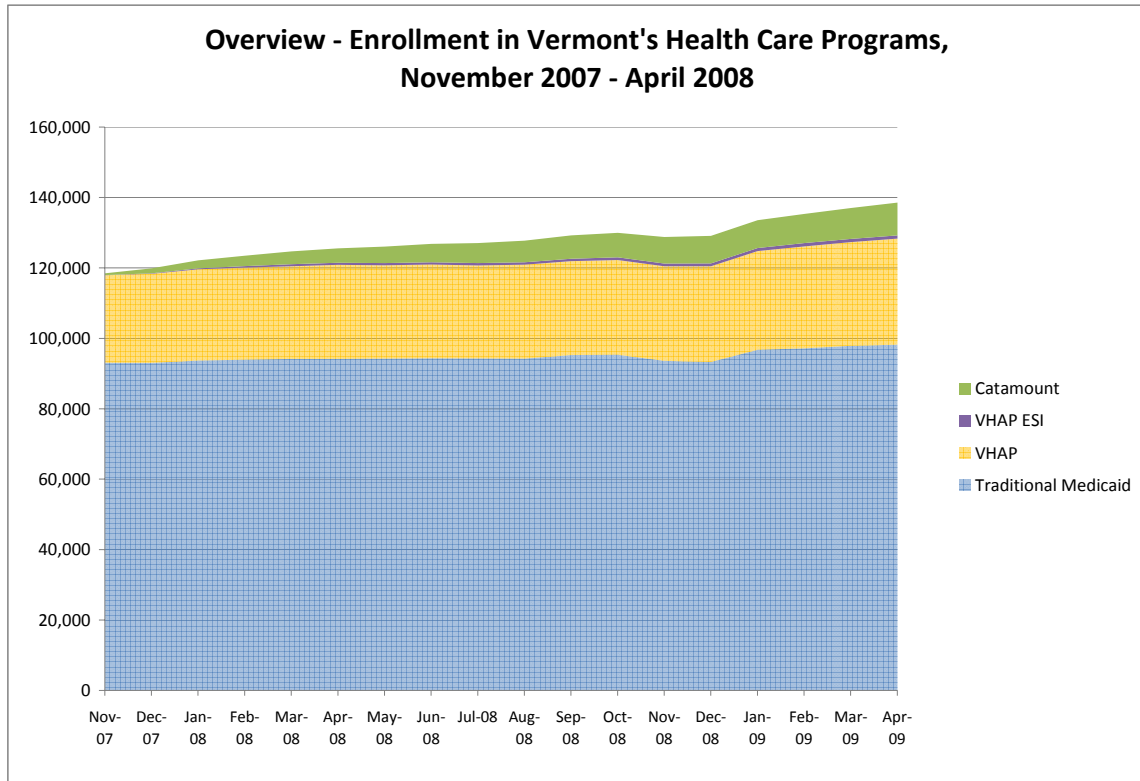
³⁵ \$200 per month for children under 2

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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, 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, 12/07 – 4/09



Enrollment in Catamount Health

Initial Catamount Health enrollment was steady, and enrollment reached about 5,000 individuals after 9 months of operation. In this sense, Catamount Health has followed a pattern that is similar to early enrollment in VHAP, which also had about 5,000 individuals after 9 months of operation.

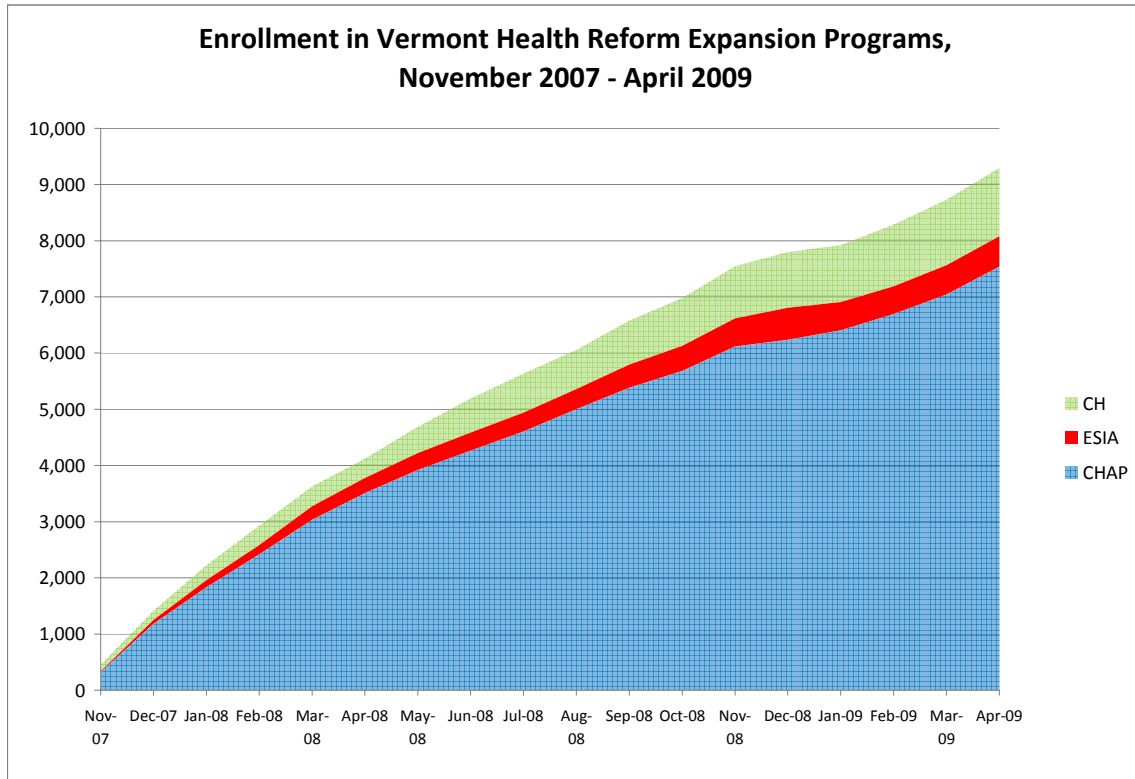
The distribution of enrollment among the three components of Catamount has been very consistent since January 2008 as shown in Figure 2. Each month, among the total enrollees in Catamount products:

- 80 to 85% have enrolled in CHAP;
- 10 to 13% have enrolled in CH (unsubsidized Catamount); while

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- 5 and 7% have enrolled in ESIA.

Figure 2: Enrollment in Catamount Health Programs



Age

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 greater percentage of the uninsured are 18-34 year olds, so the insurers expected that this cohort would make up a greater 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 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.

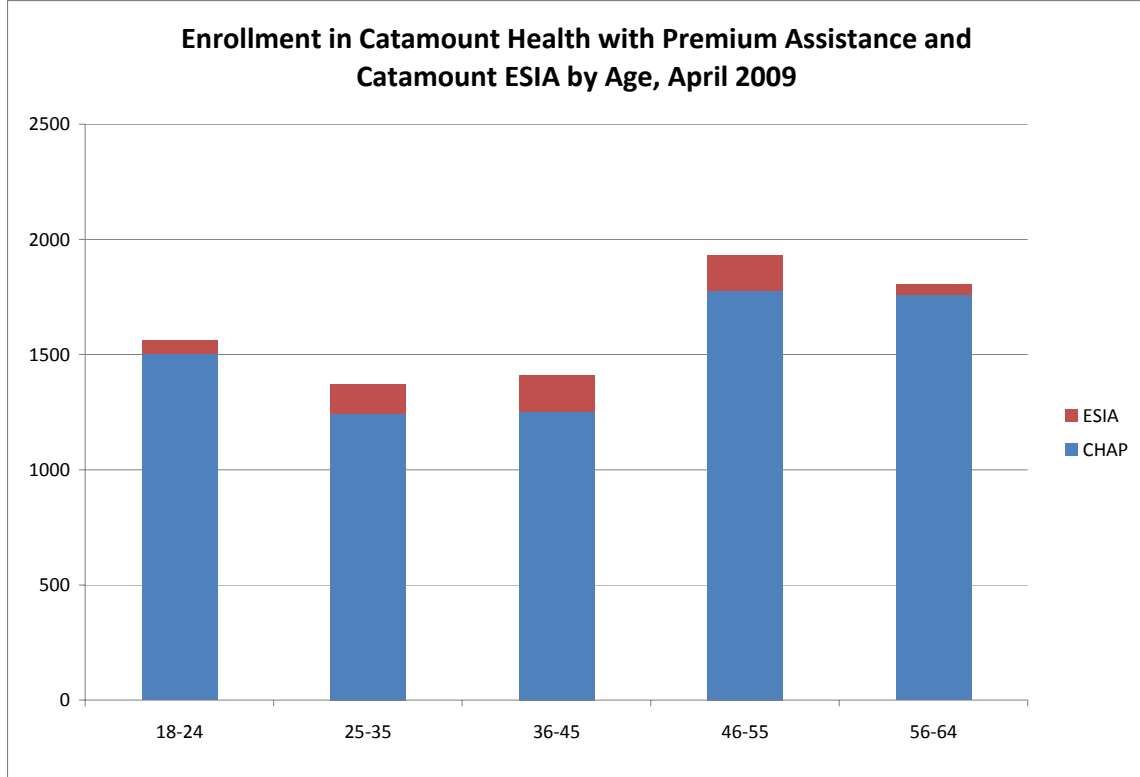
One of the findings of note is how the age distribution differs between CHAP and ESIA. ESI enrollment is proportionately highest in the 36-44 and 46-55 cohorts. This is probably due to an association between work history and access to ESI.

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

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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.³⁶ 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.

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%

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

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Examination of take-up rates presents a different picture than straight enrollment figures. It is clear that based on the proportion of eligibles who have enrolled, popularity of this program is highly correlated with age, with uninsured individuals between 56 and 64 more than three times as likely to enroll as individuals between 18 and 24.

Income

It is worth looking at 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).

Table 5: Enrollment by Income Level

	CHAP	ESIA	Total	Percent of Total
<50%	353	2	355	3.8%
50%-75%	81		81	0.9%
75%-100%	146	1	147	1.6%
100%-149%	553	22	575	6.2%
150-185%	2,789	196	2,985	32.1%
185%-200%	1,681	177	1,858	20.0%
200%-225%	1,016	82	1,098	11.8%
225%-250%	575	39	614	6.6%
250%-275%	243	19	262	2.8%
275%-300%	101	4	105	1.1%
Over 300%	1,220		1,220	13.1%
Total	8,758	542	9,300	

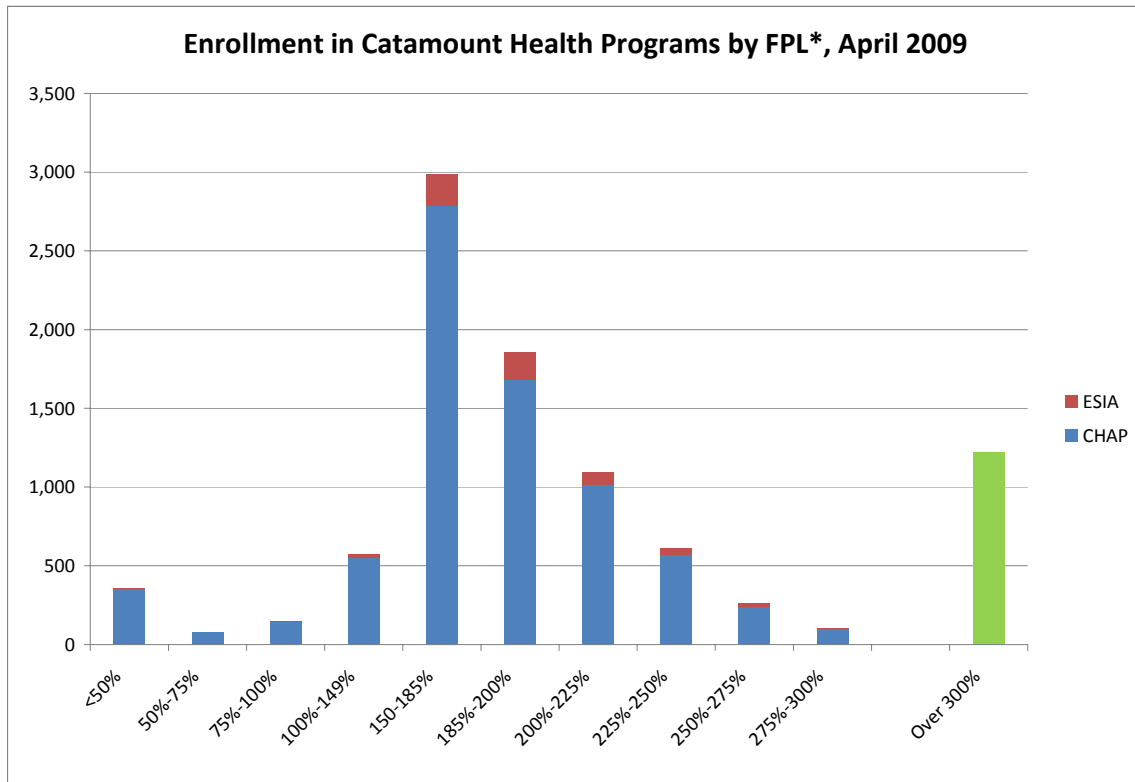
In April 2009, a total of 8,758 people were enrolled in Catamount Health. The enrollment data show some interesting trends by income:

- Approximately 13.1% of enrollees (1,220 people) have family incomes above 300% FPL and do not receive premium assistance.
- Approximately 12.5% of enrollees (1,158 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.
- More than half of Catamount enrollees have family incomes between 150 and 200% FPL.³⁷

³⁷ 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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Figure 4: Enrollment in Catamount Health Programs by FPL



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 (2003).

Administrative and legislative staff have developed a model of enrollment growth based on each month's increase being a fixed percent of the previous month. This model suggested that enrollment will level off quite soon. However, while this model was quite accurate until mid-2008, it has consistently underestimated new enrollment since then. A new model is under development.

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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) which was first conducted throughout the state in 2005 and repeated in November of 2008. Vermont contracted with Market Decisions, an independent research firm, to conduct this survey 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, this 2008 survey reflects one full year of Catamount and ESI implementation. This survey will be repeated in 2009 in order to give a more comprehensive assessment of the results of the reforms, but the 2008 findings suggest some interesting trends worth exploring in this preliminary evaluation report. More details about the methodology and findings of the 2005 and 2008 VHHIS surveys can be found in the initial findings paper presented to the legislature earlier this year.³⁸

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 and 2008?
- 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 2008, we first looked at 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.

³⁸ **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

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

	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%
Vermont Raw Differential	2.2%*	1.8%	0.4%	-2.2%*

* Difference is significant at $p < .05$ 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.

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 both 2005 and 2008. 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 Year 1 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 2008 are shown below.

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Table 7: Means and Differentials for Vermont Health Insurance Enrollment (Age 0-64)
2005 - 2008

	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%	22.9%	68.3%	8.8%
Vermont Raw Differential	2.4%*	1.6%	0.8%	-2.4%*

* Difference is significant at p<.05 level

As Table 7 shows, the percentage of non-elderly with any insurance coverage in Vermont increased by 2.4% to a little over 91% covered, a statistically significant increase. Table 8 below shows coverage trends during the same period for all of New England 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. Although health insurance enrollment increased slightly in New England during this same time period, Vermont's increase of 2.4% was substantially greater than in the remainder of New England (excluding MA and VT) which increased less than 1%.

Another finding from this comparison is that Vermont had coverage levels comparable to New England in 2005 and now has higher rates in 2008. About two-thirds of the increase in Vermont's overall coverage came through increases in public coverage. Vermont experienced a 1.6% increase in public health insurance compared to almost no increase among publicly insured for New England as a whole. These findings suggest that Vermont's health reform programs may be a factor in the observed increases in insurance coverage for the state. Finally, the fact that private insurance coverage rose more in Vermont than in New England overall, suggests that crowd-out has not been an important problem.

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

	Any Insurance	Public Insurance	Private Insurance	Uninsured
Mean Value (Health Insurance Enrollment 2005)	88.2%	17.2%	71.0%	11.8%
Mean Value (Health Insurance Enrollment 2008)	89.0%	17.3%	71.7%	11.0%
New England Raw Differential	0.75%	0.07%	0.68%	-0.75%

Public Coverage Trends

In order to better understand the increases in public coverage experienced in Vermont between 2005 and 2008, we examined changes in both eligibility for public coverage and enrollment in public coverage, or take-up, among populations with various demographic factors. Table 9 below shows the changes in eligibility and enrollment for public 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 three columns in the table for each year of the survey. The first column is the proportion of the population with public insurance; the second is the proportion eligible for public insurance (based on income and household size); and the third column is the proportion of those eligible covered by public insurance. The two columns on the right show the change in this third 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 in groups with incomes below 200% FPL. Despite increased eligibility, the proportion of the population with public coverage did not rise in most newly eligible groups over 200% FPL. In the group between 200-250% of FPL, only about 1 in 5 of those eligible took up public coverage in 2008. In the group between 250-300% FPL, only about 1 in 8/9 of those eligible took up public coverage. By contrast, in the group between 175-200% FPL, take-up rates averaged about 40% in 2008.

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Table 9: Changes in Eligibility and Enrollment in Vermont's Public Insurance in 2005 and 2008 by Selected Characteristics
(Age 0-64)

Characteristic	Public Insurance (All Covered)						Difference in Proportion of Eligible Insured (%)	Two-Sided Significance (p<.05)
	2005			2008				
	Proportion of population with Public Insurance	Proportion of population Eligible for Public Insurance	Proportion of Eligibles Insured	Proportion of population with Public Insurance	Proportion of population Eligible for Public Insurance	Proportion of Eligibles Insured		
Household Income to Poverty Ratio								
0-175%	53.4%	95.1%	56.1%	62.0%	100.0%	62.0%	5.9%	
176-185	41.6%	77.1%	53.9%	46.7%	100.0%	46.7%	-7.2%	
186-200	30.2%	43.9%	68.9%	39.6%	100.0%	39.6%	-29.3%	*
201-225	32.0%	46.1%	69.5%	18.0%	100.0%	18.0%	-51.5%	*
226-250	18.3%	33.2%	55.0%	22.3%	100.0%	22.3%	-32.7%	*
251-275	17.1%	36.7%	46.5%	14.1%	100.0%	14.1%	-32.4%	*
276-300	9.8%	32.4%	30.3%	10.2%	100.0%	10.2%	-20.2%	*
>300	4.1%	4.1%	100.0%	3.9%	3.9%	100.0%	0.0%	
Top 25%	2.6%	2.6%	100.0%	2.7%	2.7%	100.0%	0.0%	
Bottom	54.9%	97.5%	56.3%	63.9%	100.0%	63.9%	7.6%	*
Age								
0-17	41.0%	63.0%	65.0%	41.6%	58.5%	71.1%	6.0%	*
18-24	19.4%	55.3%	35.1%	19.2%	67.8%	28.3%	-6.8%	*
25-34	16.8%	34.4%	48.9%	21.4%	60.2%	35.6%	-13.4%	*
35-44	14.4%	25.8%	55.9%	16.3%	43.4%	37.6%	-18.2%	*
45-54	11.1%	18.1%	61.5%	15.1%	38.2%	39.6%	-21.9%	*
55-64	13.7%	18.0%	75.8%	13.8%	33.7%	41.0%	-34.8%	*
>65								
Marital								
Married	10.8%	18.9%	57.1%	12.3%	36.8%	33.4%	-23.7%	*
Single	23.5%	46.7%	50.2%	27.0%	64.8%	41.8%	-8.4%	*

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Characteristic	Public Insurance (All Covered)						Difference in Proportion of Eligible Insured (%)	Two-Sided Significance (p<.05)
	2005			2008				
	Proportion of population with Public Insurance	Proportion of population Eligible for Public Insurance	Proportion of Eligibles Insured	Proportion of population with Public Insurance	Proportion of population Eligible for Public Insurance	Proportion of Eligibles Insured		
Work Status								
Full-Time	6.4%	19.0%	33.6%	5.9%	34.7%	17.0%	-16.5%	*
Part-Time	18.4%	30.0%	61.2%	21.8%	54.6%	40.0%	-21.3%	*
Non-	40.6%	55.5%	73.1%	41.9%	68.2%	61.4%	-11.6%	*
Firm Size								
<10	11.2%	23.6%	47.4%	17.3%	50.1%	34.6%	-12.7%	*
10-24	10.7%	25.9%	41.2%	10.9%	43.4%	25.1%	-16.1%	*
25-49	5.5%	17.2%	32.0%	8.5%	39.7%	21.4%	-10.6%	*
50-99	7.0%	19.7%	35.7%	9.1%	38.1%	23.9%	-11.8%	*
100-499	4.8%	14.2%	33.6%	6.3%	40.7%	15.4%	-18.2%	*
500-999	4.7%	12.0%	39.7%	5.9%	31.1%	18.9%	-20.8%	*
>1000	6.6%	18.0%	36.6%	4.8%	32.7%	14.7%	-21.9%	*
Total	21.3%	36.7%	58.2%	22.9%	49.4%	46.4%	-11.8%	

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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 2008 in Vermont. Table 9 also shows that increases in public coverage (proportion of the population with public coverage) were greatest among the populations aged 25-54, and among part-time workers and employees of very small firms.

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 in each year.

Table 10 shows the results of the Accounting Decomposition comparing 2005 and 2008 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 2008 (always eligible) is contrasted with the percent eligible for public coverage in 2008 only (newly eligible) and those not eligible for public programs in either year (never eligible). Changes in all four insurance categories are examined within each of these three groups.

In 2005, 32.9% of the population of Vermont was eligible for public insurance. In 2008, 47.6% of the population was eligible. This increase in eligibility 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 3.1% among those who had always been eligible for public insurance. Insurance coverage rates increased 3.5% among those who were newly eligible for public coverage. Coverage rates increased 1.1% among those who were never eligible for public coverage. Uninsurance rates fell correspondingly.

For those in the always-eligible category, the increase in insurance came from a substantial increase in public insurance coverage (6.6%), offset by a drop in private insurance coverage (3.6%). This, again, indicates that enrollment into existing Medicaid programs increased between 2005 and 2008 among those always eligible, suggesting that

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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 increase in insurance came from increases in both public coverage (0.7%) and private coverage (2.9%). For those in the never eligible category, there was a slight drop in public coverage and private coverage increased by 1.2%. It is notable that private coverage rates rose more in the newly-eligible category than in the never eligible category. This pattern suggests that new eligibility for public coverage did not crowd-out private coverage. Those who did not gain eligibility were no more likely to gain private coverage than were those who did gain eligibility.

Table 10: Accounting Decomposition Table
(Age 0-64)

	2005	2008	2005	2008
Any Health Insurance Coverage	% Eligible	% Eligible	% Insured	% Insured
Eligible for Public Coverage in 2005 and 2008	32.9%	32.0%	83.6%	86.7%
Eligible for Public Coverage in 2008 only	17.2%	15.6%	80.7%	84.2%
Not eligible for public coverage in either 2005 or 2008	49.8%	52.4%	95.0%	96.1%
Public Health Insurance	% Eligible	% Eligible	% with public insurance	% with public insurance
Eligible for Public Coverage in 2005 and 2008	32.9%	32.0%	53.3%	59.9%
Eligible for Public Coverage in 2008 only	17.2%	15.6%	11.7%	12.4%
Not eligible for public coverage in either 2005 or 2008	49.8%	52.4%	3.5%	3.4%
Private Health Insurance	% Eligible	% Eligible	% with private insurance	% with private insurance
Eligible for Public Coverage in 2005 and 2008	32.9%	32.0%	30.4%	26.8%
Eligible for Public Coverage in 2008 only	17.2%	15.6%	68.9%	71.8%
Not eligible for public coverage in either 2005 or 2008	49.8%	52.4%	91.5%	92.7%
Uninsured	% Eligible	% Eligible	% uninsured	% uninsured
Eligible for Public Coverage in 2005 and 2008	32.9%	32.0%	16.4%	13.3%
Eligible for Public Coverage in 2008 only	17.2%	15.6%	19.3%	15.8%
Not eligible for public coverage in either 2005 or 2008	49.8%	52.4%	5.0%	3.9%

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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.³⁹ 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 regression-based decomposition analyses of insurance coverage using the CPS data have been performed in prior research⁴⁰. We use the base year of the pairwise comparison (2005 for the 2005–2008 comparison) as the point of reference. The basic formula for the Oaxaca decomposition is as follows:

$$HI^{08} - HI^{05} = X^{08} * (B^{08} - B^{05}) + B^{05} * (X^{08} - X^{05})$$

where *HI* measures health insurance, *X* is a regressor, and *B* is a vector of coefficients that give the probabilities of obtaining insurance for each *X*. In the analyses that follow, we include 9 *X* vectors: 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 11 below.

Table 11: Oaxaca Decomposition Regression Results (Age 0-64)

Oaxaca Decomposition – Any Coverage			
	Coefficients	Means	Total
Vermont	4.5%	-2.0%	2.4%
New England	0.61%	0.13%	0.74%
USA	-0.56%	0.09%	-0.47%

Oaxaca Decomposition – Public Coverage			
	Coefficients	Means	Total
Vermont	0.5%	0.9%	1.4%
New England	0.61%	-0.54%	0.07%
USA	0.69%	-0.21%	0.48%

³⁹ [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.

⁴⁰ 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.

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Oaxaca Decomposition—Private Coverage			
	Coefficients	Means	Total
Vermont	3.9%	-3.0%	1.0%
New England	0.00%	0.67%	0.67%
USA	-1.25%	0.30%	-0.95%

The Oaxaca decompositions suggest very different coverage changes occurred in Vermont, New England, and the United States overall. Coverage increased most in Vermont. In New England, excluding Vermont, there was a small increase in coverage. In the US as a whole, coverage fell over the 2005-2008 period. The increase in coverage in Vermont mainly came through an increase in public coverage. There was also an increase in public coverage nationwide. Private coverage fell nationally, but increased slightly in New England, and more in Vermont.

In Vermont, changes in the propensity to take up coverage explain the increase in private coverage and, hence, the increase in overall coverage. Changes in socioeconomic characteristics of the Vermont population – particularly a decline in full-time work, a decline in the share of the population reporting excellent health, and a reduction in single person households – acted in the opposite direction, moderating the increase in private coverage. Public coverage in Vermont grew both because of a modest uptick in the propensity to take up coverage conditional on characteristics and because of favorable changes in the distribution of population characteristics.

In New England, and in the US overall, there was a somewhat larger increase in the propensity to take up coverage, conditional on characteristics, than in Vermont, but shifts in population characteristics mitigated the effect of these propensity changes. Nationwide, there was a large decline in the propensity to take up private coverage given population characteristics.

Overall, comparing across geographic areas, these decomposition results suggest that coverage expansion in Vermont were owed primarily to an increase in the propensity to take up coverage, including the propensity to take up private sources of coverage. Changes in the composition of the population worked against coverage expansion in the state. The decomposition results also suggest that crowd-out of private coverage was not an important explanation of the Vermont expansion experience.

Private Coverage and Crowd-Out

To further examine the issue of crowd-out we examined changes in private coverage among various income groups as shown in Table 12 below. Private coverage fell in the lowest income category (<175%) and in the groups with incomes 186-200%FPL and 226-250% FPL. The former group had always been eligible for public insurance, while the latter groups saw substantial increases in the share of the population eligible for public coverage. For most groups with substantial increases in the share eligible for public coverage, however, private coverage rose.

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Table 12: Changes in Eligibility and Enrollment in Private Insurance in 2005 and 2008 by Selected Characteristics (Age 0-64)

Characteristic	Private Insurance (Except duals counted in public)				Difference in Proportion Privately Insured (%)	P-Value (Two-Sided Significance)
	2005		2008			
	Proportion of population Eligible for Public Insurance	Proportion of population Privately Insured	Proportion of population Eligible for Public Insurance	Proportion of population Privately Insured		
Household Income to Poverty Ratio						
0-175%	95.1%	25.9%	100.0%	22.3%	-3.6%	
176-185	77.1%	40.0%	100.0%	41.3%	1.3%	
186-200	43.9%	53.2%	100.0%	42.6%	-10.7%	
201-225	46.1%	52.3%	100.0%	67.6%	15.4%	*
226-250	33.2%	68.8%	100.0%	63.4%	-5.4%	
251-275	36.7%	71.8%	100.0%	78.0%	6.3%	
276-300	32.4%	78.1%	100.0%	80.0%	1.9%	
>300	4.1%	91.0%	3.9%	92.2%	1.2%	
Top 25%	2.6%	94.4%	2.7%	94.7%	0.3%	
Bottom	97.5%	24.4%	100.0%	20.2%	-4.2%	
Total	36.7%	67.5%	49.4%	68.3%	0.8%	

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PRELIMINARY FINDINGS FOR VERMONT EMPLOYERS' HEALTH COVERAGE

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? This report presents baseline 2006 data on employer insurance coverage in Vermont that, in the future, could be compared to post-implementation data on employer insurance coverage to gauge the impact of reforms on the employer insurance market.

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 recent 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.⁴¹ 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 the population.

Compared to the New England state average and the nation as a whole (See Table 13), Vermont has a greater percentage of very small firms (<10 employees) and a lesser percentage of very large firms (>1000 employees). Because Vermont's firms tend to be smaller than other states, including other New England states, the state may face unique challenges with respect to employer-based insurance.

Table 13: Percentage of private sector firms by number of employees

	VT	New England Average	National
< 10 employees	64.4%	60.1%	57.8%
10-24 employees	11.8%	12.5%	12.3%
25-99 employees	8.1%	8.2%	8.2%
100-199 employees	6.6%	7.4%	6.6%
1000 or more employees	9.1%	11.8%	15.1%

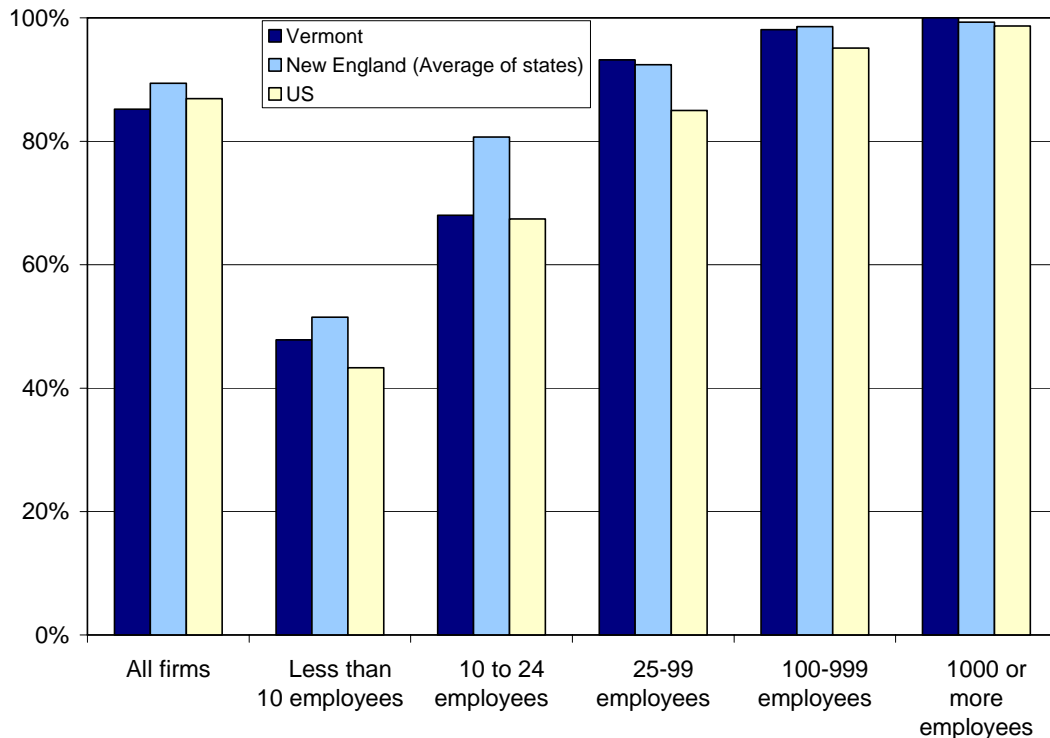
⁴¹ Kauffman-Rand Institute for Entrepreneurship Public Policy. Is the Burden of Providing Health Insurance Greater for Small Firms than for Large Firms. 2008. http://www.rand.org/pubs/research_briefs/2008/RAND_RB9340.pdf. Accessed June 1, 2009.

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Vermonters Were Less Likely to Work for Firms that Offer Health Insurance than Regional or National Counterparts

In Vermont, 85% of private-sector employees worked for firms that offer health insurance in 2006. This percentage was lower than the average percentage of private-sector employees who work for firms that offer health insurance in New England (89.4%) and nationally (86.9%). However, the main reason that Vermont employees were less likely to work for firms that offer health insurance is that a larger proportion of Vermont firms are small (<10 employees), as discussed above. When stratified by the size of the firm, Vermont employees were more likely to be offered insurance than the national average for each size of firm (See Figure 5); however, Vermont employees still tended to be less likely to be offered insurance than employees in the New England states.

Figure 5: Percent of private-sector full-time employees in establishments that offer health insurance (by firm size)



Vermonters Were Less Likely to Enroll in an Employer Health Plan Offered to them than Regional or National Counterparts

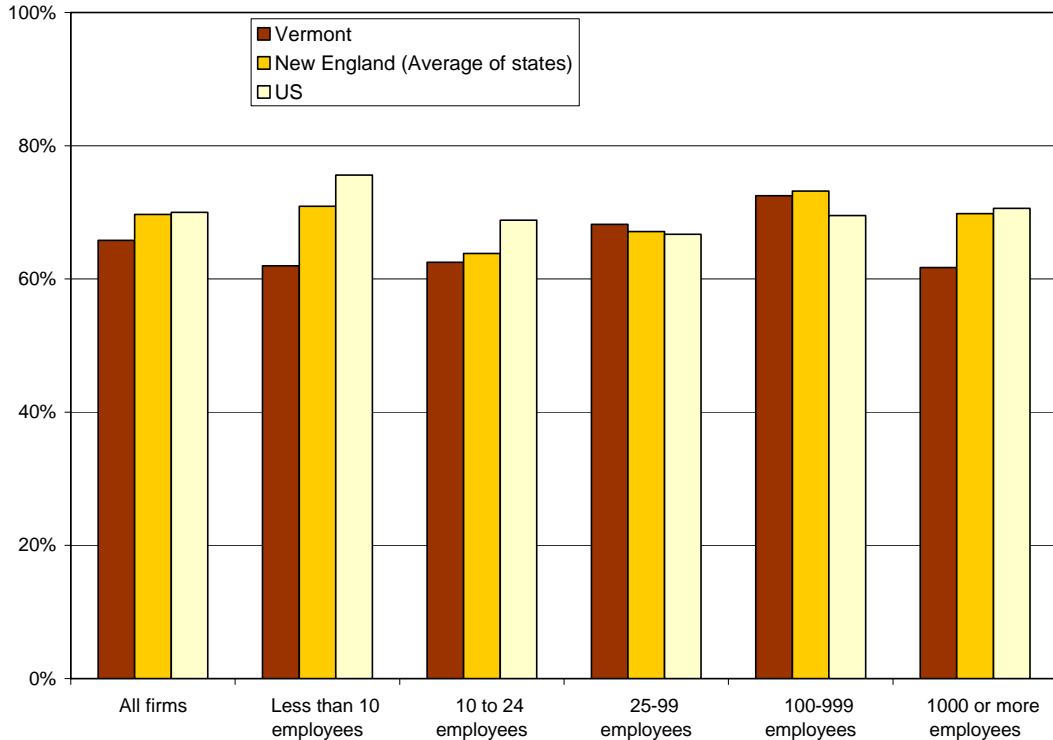
Among private-sector full-time Vermont employees who worked at firms that offer health insurance, 65.8% enrolled in that insurance in 2006. In comparison, the New England average enrollment rates (for employees working at firms that offer insurance) are 69.7%, and the US average enrollment rates were 70.0%.

Enrollment rates by firm size are presented in Figure 6. Enrollment rates in Vermont were consistently lower than the New England average and the national rates, with a few

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exceptions. Vermont enrollment rates are particularly low for firms with less than 10 employees (62.0%). In our Year 2 report, through process evaluation and additional data collection, we will examine whether enrollment rates have remained low since the passage of the HCAA and will examine the potential factors that have contributed to these low enrollment rates (e.g., business type, adequacy of insurance plan, income of employees, etc.),

Figure 6: Percent of private-sector full-time employees that are enrolled in health insurance at establishments that offer health insurance (by firm size)



Some of those who did not enroll in insurance were not eligible for the employer-sponsored insurance (e.g., have not worked long enough, job does not qualify them). Among those who are eligible, 74.5% of Vermonters enrolled in an offered plan. This is lower than the national average of 78.3%.⁴²

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.

⁴² Vermont Department of Banking, Insurance, Securities and Health Care Administration. Frequently Asked Questions about the Health Insurance Market in 2007. http://www.bishca.state.vt.us/HcaDiv/Data_Reports/healthinsurmarket/FAQ2007_11-08.pdf. Accessed May 30, 2009.

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The 2006 MEPS data shows some interesting trends 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 regional comparison groups.
- There were some aspects of Vermont plans that did not compare favorably to regional 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 regional and national averages. Those employees enrolled in plans with coinsurance for physician office visits also were required to pay a greater percentage than their regional or national counterparts.
- Vermont employees were significantly less likely to have a copayment than regional or national comparison groups.

Table 14: Premiums, Deductibles, and Co-pays for Private Sector Employees
with Insurance through their Employer

	VT	New England Average	National
Premiums for Single Coverage			
Average total premium	\$4,322	\$4,509	\$4,118
Average total employee contribution for coverage	\$738	\$924	\$788
Percent of total premiums contributed by employees	17.1%	20.4%	19.1%
Premiums for Family Coverage			
Average total premium	\$11,631	\$12,220	\$11,381
Average total employee contribution for coverage	\$2,619	\$3,006	\$2,890
Percent of total premiums contributed by employees	25.4%	24.5%	22.5%
Deductibles			
Percent of employees enrolled in a health insurance plan that had a deductible	72.5%	54.9%	66.4%
Average deductible for single coverage	\$936	\$707	\$714
Average deductible for family coverage	\$2,016	\$1,456	\$1,351
Copayment/Coinsurance			
Percent of employees enrolled in a health insurance plan that had a copayment for an office visit to a physician	67.8%	82.3%	74.9%
Average copayment for employee enrolled in a plan with copayments	\$19	\$18	\$19
Average coinsurance (%) for an office visit to a physician per employee enrolled in a plan with coinsurance	19.7%	18.3%	18.5%

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VII. SUSTAINABILITY

Background

Financial sustainability – the ongoing balance between revenues and expenditures – is central to successful health care reform. The financing of Vermont’s reform efforts was designed to be sustainable for several years, but it was clear that longer-term sustainability would be a challenge, due in part to the use of funding sources such as cigarette and tobacco taxes that are expected to decline over time.

A program can be sustainable in two ways. The first is that operational revenue is fully adequate to cover operational expenses. If this is not the case, the second is that sufficient supplemental funding⁴³ is available from other sources to cover operational shortfalls. To date, this has been the case for the Catamount Fund.

New programs are often characterized by positive operating results in early years, before full enrollment is achieved. In order to preserve these surpluses for future years, states often create dedicated funds and permit balances to remain in the funds, rather than reverting to the general fund.

For many years, Vermont has funded its health care programs with a combination of general funds and dedicated funds. For example, the state’s “Global Commitment” waiver has a dedicated fund, into which revenue from a variety of sources is deposited. In contrast, state funding for the “Choices for Care” waiver is entirely from the general fund.

When Catamount Health was created, the state chose to create a separate fund to finance it, rather than mixing revenues and expenses into existing funds. To evaluate the sustainability of the Catamount Health program, we will focus on this fund. We will assess the viability of the revenue streams, including the potential for cost savings from the Employer Sponsored Insurance (ESI) premium assistance program, to cover expense requirements of expanded insurance coverage.⁴⁴

Revenue deposited in the Catamount Fund comes from five sources:

- An assessment on employers who either do not offer insurance to some or all of their employees or who have employees who are eligible for coverage but are uninsured. The assessment does not apply when employees decline coverage because they have insurance from another source
- Incremental revenue from an increase in the state’s cigarette and tobacco taxes

⁴³ Defined here as funding which requires an explicit transfer from another source

⁴⁴ The financial impact of the premium assistance component of the ESI program—its impact on the health insurance offering rate and private insurance benefit design/coverage compared to CH and the VHAP is not addressed in this report. It will be addressed in year 2 and we plan to include an estimate of substitution effects (cost savings) from use of ESI premium assistance rather than CH or VHAP.

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- Beneficiary premiums
- Interest on the fund balance
- Federal Medicaid funds

While the Catamount Fund pays for many of the initiatives included in Vermont's recent reform efforts, 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
 - Blueprint for Health (partial funding)

The Catamount Fund does not pay for the costs of the VHAP ESI program.

While many different assumptions were necessary in the design of the Catamount program, one has had the most significant effect on program sustainability. During the design phase, the state strongly believed that the federal government would amend Vermont's 1115 waiver to allow federal Medicaid funds to be used to match premium subsidies for Catamount beneficiaries with household incomes up to 300% of poverty. The federal government ultimately did not approve this change, limiting the use of matching funds to 200% of FPL, which substantially increased the projected costs of the program.

Vermont took several steps in response to this decision, including transferring additional 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.

In an effort to address sustainability concerns, two links between revenue and expenses were included in the original program design. First, unlike beneficiary premiums in other state health programs, beneficiary premiums in Catamount Health were explicitly indexed to the cost of the underlying insurance product premium. This was later amended to make beneficiaries who choose the more expensive Catamount Health plan fully liable for the difference in costs.

Table 15 below provides examples of how beneficiary premiums are related to changes in the underlying insurance products. Currently, both products cost \$393.11 per month for an individual policy. A beneficiary at 180% of poverty would be responsible for \$65 per month of this cost, with the state paying the balance (\$328.11). If both plans increase by

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the same amount (10% in this example), both the beneficiary premium and the state cost would increase by 10% (to \$71.50 and \$360.92).

If the carriers are granted different increases, the last column shows how beneficiary costs and state subsidy amounts would change. Note that even though the two products have different premiums in this example, the amount the state pays in subsidy is based on the lower-cost product, and the beneficiary makes up the full difference.

Table 15: Relationship between Beneficiary Premiums and Health Plan Premiums

Plan	Current	Same Increase		Different Increase	
		Increase	New	Increase	New
A	\$393.11	10%	\$432.42	10%	\$432.42
B	\$393.11	10%	\$432.42	20%	\$471.73
Beneficiary at 180% of poverty					
A	\$65		\$71.50		\$71.50
B	\$65		\$71.50		\$110.81
Cost of Subsidy					
A	\$328.11		\$360.92		\$360.92
B	\$328.11		\$360.92		\$360.92

Second, the employer assessment, originally set at \$365 per year per FTE is also indexed to the increase in the underlying insurance products. This means that if the two insurance companies raise premiums for Catamount, the employer assessment will also increase accordingly.

Analysis

Sustainability is analyzed in this report by evaluating the fund balance over time and operating results, both monthly and cumulatively. To accomplish this we obtained information from Vermont on the aggregate (and individual) value of revenue streams that make up the Catamount Fund. Costs/expenditures for each program component of health reform were also obtained from information provided by the state. 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 CH and ESI program insurance premiums paid for by state and federal sources and not claims costs.⁴⁵

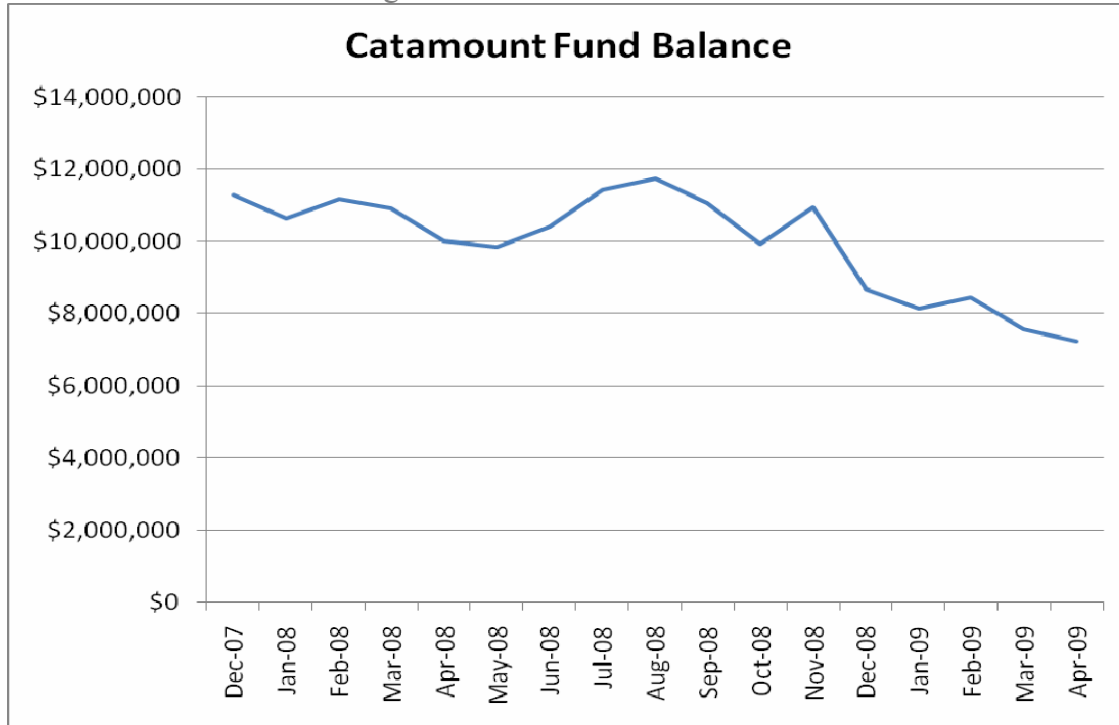
⁴⁵ We anticipate that in year 2 of the evaluation we will have access to claims data to examine the contribution of the Vermont Blueprint and other reform efforts in reducing the costs of health reform by improving chronic care management and reducing demand for higher cost services. Emergency room and hospital discharge rates for specific conditions (i.e. diabetes) from similar communities (Blueprint and non-Blueprint) will be trended over time to assess the potential impact of the Blueprint on these high cost services.

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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.

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 by April 2009, the fund balance was down to \$7.2 million.

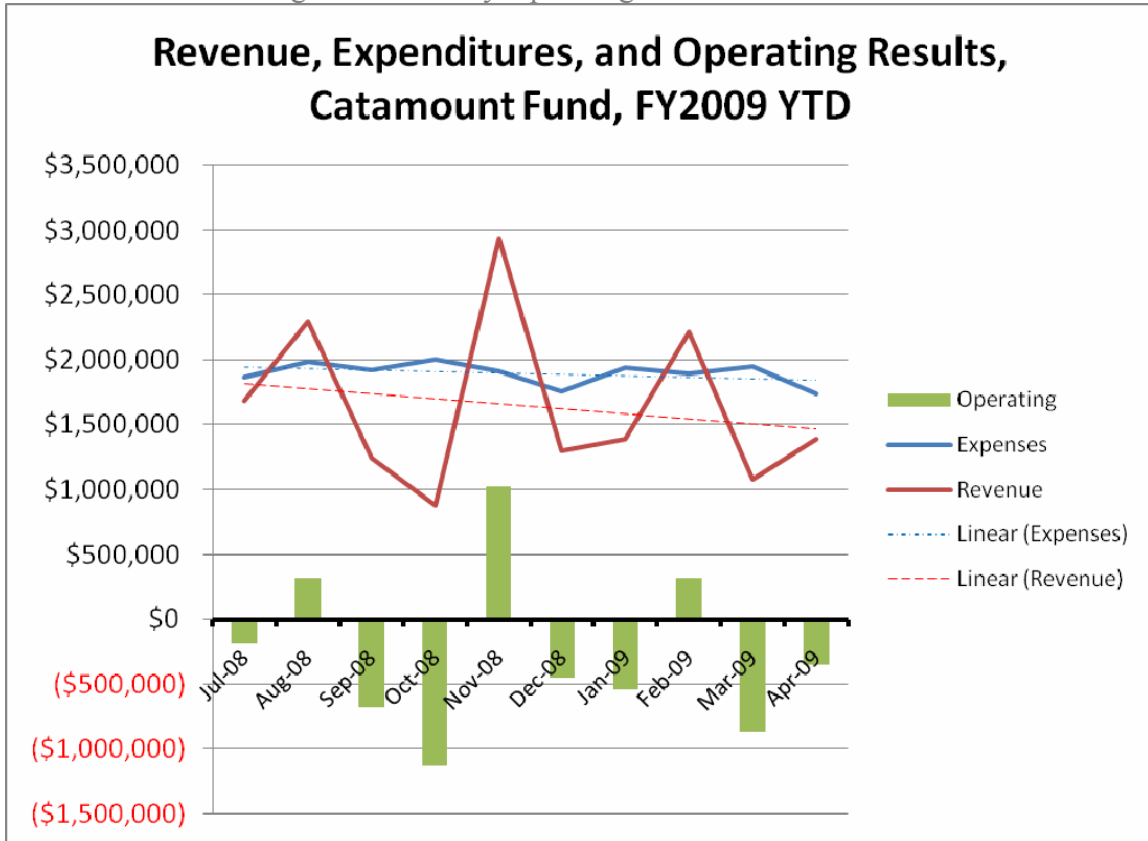
Monthly Operating Results

Analysis of monthly results can be challenging. While expenses are fairly consistent from one month to the next, affected only by changes in enrollment and the reporting process, revenue cycles vary. Payment of the employer assessment is done quarterly.

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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



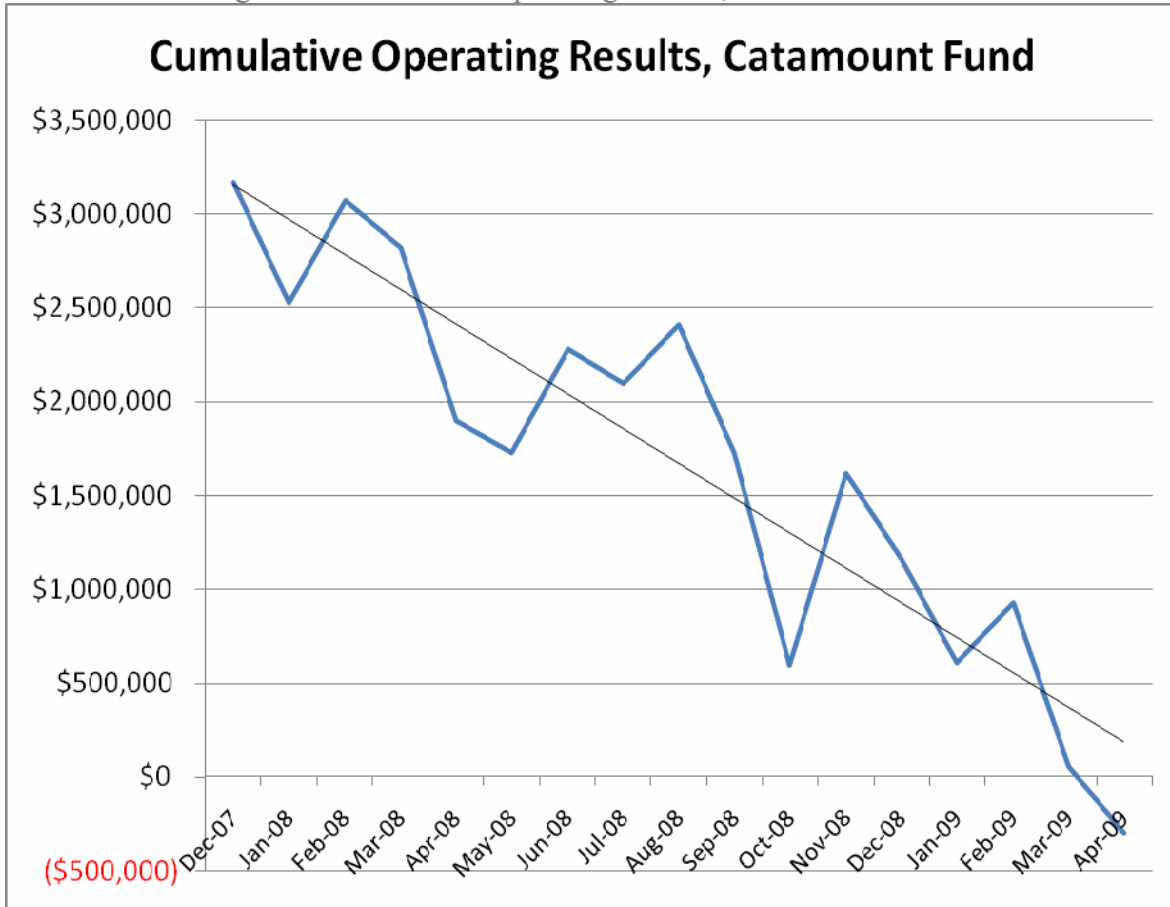
Examining only fiscal year 2009 in Figure 8 (to avoid the distortions of the changed income disregard) the challenges become apparent. Operating results were negative in seven of the ten months but, more importantly, while expenses are fairly flat (based on the results of the linear regression), revenues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

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Figure 9: Cumulative Operating Results, Catamount Fund



Conclusion and Next Steps

The long-term sustainability of the program is challenged by several different factors:

- The decision of CMS not to permit the use of matching funds to 300% of poverty
- Reliance on a declining revenue source (cigarette and tobacco taxes) for a significant portion of program funding (48% of revenue in FY 2009 through April)
- Broader economic forces
 - Impact on enrollment
 - Reduced, then eliminated supplemental contribution to offset the loss of anticipated federal funds

However, there has also been a positive contributor to sustainability – to date, neither carrier has requested a premium rate increase.

It is not surprising that the Catamount Fund, as currently constructed, faces serious challenges. If fiscal sustainability is to be achieved, a rebalancing of revenue and expenses will be necessary. The preliminary information presented here indicates that Vermont’s Health Reform programs’ fiscal sustainability as a function of premium expenditures versus tax and other revenues is not currently viable in the long term. However, since expenditures are based on premium outlays by the state and not the costs

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of providing care to program recipients, it is unclear whether the program is truly sustainable over time as enrollees needing premium assistance declines, as premiums and revenues expectations change or as costs savings incur due to improved health status of enrollees.

One policy change that will have a substantial effect on sustainability would be approval by CMS of the use of Medicaid funds for premium subsidies for Catamount Health participants between 200 and 300% of poverty. Based on April, 2009 figures, this change would save the state approximately \$450,000 per month (net of having to share premium revenue from this group with the federal government). This would reduce state spending by between 20 and 25%, a substantial savings.

The future of cigarette and tobacco tax revenue is also uncertain. Whether or not smoking rates continue to decline, the revenue that Vermont can collect from this source is also dependent on relative tax rates among Vermont and its neighbors. Vermont's cigarette tax rate will be increasing on July 1, which may impact sales volume subject to the tax.

In year 2 of the evaluation we plan to further explore these issues. For example, we plan to obtain claims data on program enrollees—this will assist us in determining the actual costs of the program to both the state and insurers. It may also permit us to assess the health status of program enrollees and their patterns of care over time. We expect to be able to calculate and trend member per month costs against revenues. This will provide a more accurate picture of program sustainability and in turn permit a more informed policy discussion of mechanisms to address sustainability.

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VIII. CONCLUSIONS, DESCRIPTION OF YEAR 2 EVALUATION ACTIVITIES, AND OTHER NEXT STEPS

Summary of Findings

In the first year of our evaluation of Vermont's 2006 Health Reform, the focus has been on the process evaluation in order to glean insights and experiences to date about the 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 4 bills have been passed to date to modify and clarify the original HCAA health reforms and address these barriers.

Key informants 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. Those we spoke too 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. Among other issues, the legislature will soon review the costs of the public/private insurance plan design of Catamount Health and whether an individual mandate is needed to reach near-universal insurance coverage in Vermont. Informants are also optimistic that additional support for the programs will be received from the federal government in the future.

In order to provide some preliminary 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 compared to 2008. Despite the barriers cited above, enrollment in the new Catamount Health program increased sharply and steadily during the initial months. By April 2009, a total of 8,758 people were enrolled in the new Catamount Health program. Most of these enrollees receive premium assistance. Only 13.9% of enrollees have family incomes above 300% FPL and do not receive premium assistance.

Between 2005 and 2008, 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

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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 3.1% among those who had always been eligible for public insurance and 3.5% among those who were newly eligible for public coverage. In comparison, coverage rates increased more moderately (1.1%) among those who were never eligible 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 5.5%, while enrollment in VHAP increased by 21.0%.

Sustainability of Vermont's health reforms is an important issue to the State and outside observers. Although it would be premature to make conclusions about the sustainability after less than 2 years of implementation, expenditure and revenue data provide some indication of whether new program costs are being adequately covered by revenue sources. 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, state revenues from all sources were approximately \$7.6 million. Since December 2007 the fund balance has declined as program revenues are not keeping pace with expenditures. Unless program expenditure patterns change, new sources of revenues are found or structural changes in the plans occur, the fund balance will be depleted over time. The preliminary information presented here indicates that program fiscal 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. These areas will be explored in the coming year.

Limitations of Current Analysis

Although this report provides much information about Vermont's experience to date with health reform, there are limitations to this first evaluation report due primarily to unavailability of some needed datasets and the limited amount of time that has elapsed since implementation of the new programs.

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Our analysis is limited to datasets available at the time of report preparation. In some cases, such as with the Vermont Fringe Benefit Survey, we have yet to obtain the full 2007 dataset due to staffing shortages in department responsible for this survey. In fact, there are indications that the 2009 replication of this survey may not be funded at all. We will continue to attempt to access the full dataset for the 2007 Fringe Benefit survey and have begun looking for additional sources of information on this topic for next year's report.

In other situations, such as with the Vermont Household Health Insurance Survey, there will be another survey in 2009 which will provide more information about coverage trends in Vermont over time. We anticipate that findings after two years of health reform implementation will provide additional information that will inform this analysis further.

Finally, there are datasets which we had anticipated being part of public reporting by the State, such as disenrollment figures and claim expenditures for Catamount participants, but which have not been made available at this time. We anticipate continuing to work closely with the state of Vermont in order to determine the best mechanism for accessing and analyzing this information to improve the usefulness of our findings.

Despite these limitations, the reform package looks promising as a vehicle to provide access to care 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 preliminary analyses of enrollment, affordability, and sustainability of Vermont's new health coverage programs. This information, while not conclusive after less than 2 years of program implementation, provides valuable insights to inform future reform efforts in Vermont and in other states experimenting with health care reform legislation.

Next Steps and Future Analyses

In the second year of our evaluation activities, we plan to refine and expand our analyses to incorporate an additional year of data, answer new questions, and improve our analytical methods. We will also examine an area we have not yet explored -- the impact of the reforms on access to care.

In the coming year, we plan to conduct additional key informant interviews in order to update the process evaluation findings. In terms of addressing the affordability of Vermont's reform programs, we will further explore enrollment data from OVHA to conduct a churn analysis, examining the rates and reasons for disenrollment from Catamount, as well as an examination of transfer rates from VHAP to VHAP ESI programs to better understand the impact of these programs. We will also use VHHIS 2009 results to analyze take-up rates in Catamount by health status and age.

In year 2 of the evaluation we plan to further explore sustainability with additional data and focus. For example, we plan to obtain claims data on program enrollees—this will assist us in determining the actual costs of the program to both the state and insurers. It may also permit us to assess the health status of program enrollees and their patterns of care over time. We expect to be able to calculate and trend member per month costs against revenues. This will provide a more accurate picture of program sustainability and in turn permit a more informed policy discussion of mechanisms to address sustainability.

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IX. APPENDIX 1 - LIST OF KEY INFORMANTS

Vermont State Administration

Susan Besio

Director

Office of Vermont Health Access (OVHA)

Vermont Health Care Reform

Tom Douse

Deputy Commissioner

Department of Labor

Betsy Forrest

Director

Catamount and ESI Premium Assistance Programs

OVHA

Dian Kahn

Director of Analysis and Data Management

Department of Banking, Insurance, Securities & Health Care Administration (BISHCA)

Christine Oliver

Deputy Commissioner

Division of Health Care Administration

BISHCA

Herb Olson

General Counsel

BISCHA

Val Rickert

Director, UC & Wage

Department of Labor

Joshua Slen

Interim Director

Vermont Information Technology Leaders (VITL)

Kevin Veller

Director of Health Care Reform Outreach & Enrollment

OVHA

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Vermont Legislature

Senator Jane Kitchel

Representative Steven Maier
Chair of House Health Care Committee (past and current)

Representative John Tracy
Former - Chair of Health Care Reform Committee
Current - Aide to U.S. Senator Patrick Leahy

Non-Governmental Stakeholders

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

Donna Sutton Fay
Chittenden County Field Staff
Vermont Campaign for Health Care Security Education Fund

Bea Grause
Executive Director
Vermont Association of Hospitals & Health Systems

Jim Hester
Former VP for MVP HealthCare
Current Director, Legislative Commission on Health Care Reform

Bill Little
VP of Vermont
MVP Health Care

Lila Richardson
Legal Counsel
Vermont Coalition for Disability Rights (VCDR)

Kate Simmons
Acting Vermont Public Policy Director
Bi-State Primary Care Association

Jennifer Wallace-Brodeur
Associate State Director, State and Community Development
AARP Vermont

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X. APPENDIX 2 – PROCESS EVALUATION DOMAINS & QUESTIONS

Dimension	Study Questions	Overarching Interview Domains	Interview Questions
Process Evaluation	<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 the process worked and how they are managing the changes</p> <p>Expected future directions in Vermont’s health reform efforts</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 were 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.,

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Dimension	Study Questions	Overarching Interview Domains	Interview Questions
			<p>in Catamount Health, in ESI premium assistance, in Medicaid)?</p> <ul style="list-style-type: none"> • 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 reform in your state and how can they be fixed? • What do you think was the most important goal of the legislation?" <p>For Insurers:</p> <ul style="list-style-type: none"> • What role, if any, did your company played in development of the legislation and in the implementation process? Have you worked closely with the state on issues around implementation? • What issues has your company had during the implementation phase? Are there ways that the state could have facilitated this process?
Affordability of Health Insurance and Enrollment	Are the insurance plans affordable as measured by enrollment of the uninsured across demographic, socioeconomic, and geographic groupings?	<p>Reasons that some eligibles are not signing up.</p> <ul style="list-style-type: none"> • Perceptions of individuals • Perceptions of eligibility workers/outreach program <p>Accuracy of eligibility determination process for Catamount Health</p> <ul style="list-style-type: none"> • There should not be crowd out if done correctly (though new businesses may not offer insurance if Catamount Health available) • Extent to which health reform has pushed people onto employer plans 	<ul style="list-style-type: none"> • What, if any, impact do you think that the state's healthcare reform initiative has had on providing coverage to the uninsured or underinsured? • What, if any, impact do you think that the state's healthcare reform initiative has had on improving affordability for insurance for the uninsured or underinsured? • Is the initiative reaching the people who need access to healthcare? <p>Outreach Program:</p> <ul style="list-style-type: none"> • Please describe the outreach efforts you are using.

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Dimension	Study Questions	Overarching Interview Domains	Interview Questions
	<p>To what extent is new coverage drawn from pool of people who would otherwise be privately insured (crowd out)?</p> <p>How have the health reforms impacted premiums and out-of-pocket costs?</p>	<p>Changes in the private insurance market enrollment since enactment of Catamount Health due to other factors.</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) • How well they're doing financially • Whether they have any specific marketing approach to CH 	<ul style="list-style-type: none"> • Why do you think some individuals are choosing not to sign up? What distinguishes those who sign up from those who do not? <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 has 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)? • How well are you doing financially with respect to CH? • Do you have any specific marketing approach to CH?
	<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</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? • Who is dropping existing coverage? • Who is deciding to offer? 	<ul style="list-style-type: none"> • How do employers feel about the employer assessment? Do they perceive it as "fair"? • What has been the business community's response? Is anybody dropping coverage? Is anybody deciding to offer coverage?

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Dimension	Study Questions	Overarching Interview Domains	Interview Questions
	<p>CH/VHAP?</p> <p>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>	<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> <ul style="list-style-type: none"> • Are they seeing a surge? 	<p>Bistate Primary Care Assoc/Medical Society</p> <ul style="list-style-type: none"> • What changes to FQHCs and FQHC look-alikes have occurred as a result of the health reform? • 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?
<p>Access to Care</p>	<p>What effect do these policies have on the size of the population with a usual source of care?</p> <p>What effect do the policies have on ER use by patients diagnosed with ambulatory care sensitive conditions?</p> <p>What are the specific health care use patterns of the newly-insured?</p>	<p>Changes in size of primary care provider workforce since health reform.</p>	
<p>Sustainability</p>	<p>How viable are the funding sources over time?</p>	<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"> • 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

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Dimension	Study Questions	Overarching Interview Domains	Interview Questions
		<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 will happen in future? 	<p>program?</p> <ul style="list-style-type: none"> • 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?

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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 otherwise 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)

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)