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## Achieving Universal Coverage through Comprehensive Health Reform: The Vermont Experience – Evaluation Results

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### INTRODUCTION

Vermont's comprehensive health reform law, the Health Care Affordability Acts (HCAA) for Vermonters, was passed in 2006 with the following three goals in mind:

1. To achieve universal access to affordable health insurance for all Vermonters
2. To improve quality of care and contain costs through health system reform
3. To promote healthy behavior and disease prevention across the lifespan



To achieve the first goal, the HCAA created two programs intended to provide access to affordable insurance to the state's uninsured: The Catamount Health Insurance Program (Catamount Health) and the Employer-Sponsored Health Insurance (ESI) Premium Assistance Program. Blueprint for Health (which is currently being implemented) is an initiative that was created to address the second and third goals of the HCAA, focusing on the prevention and management of chronic conditions to improve quality of care and reduce health care costs (Conis, 2008).

This brief presents key findings from a two-year comprehensive evaluation examining the impact of health care reform in Vermont under the HCAA. The authors analyzed three key dimensions of Vermont's comprehensive health reform: health coverage affordability, access to health coverage, and sustainability of the reforms.

### DATA AND METHODS

Several data sets were used to assess the impact of Vermont's health reform on public, private, and self-insured coverage options; enrollment; premiums and other out-of-pocket costs; program administrative costs; and related measures. These data sets included: administrative data on enrollment; the 2005, 2008 and 2009 Vermont Household Health Information Survey (VHHIS); the Current Population Survey (CPS); the 2006, 2008, and 2009 Medical Expenditure Panel Survey (MEPS); and the Department of Vermont Health Access (OVHA) revenue and expenditure data. Additionally, interviews with key informants were used to clarify the historical context, policies, and practices involved with HCAA implementation and to gain insight around lessons learned that might be helpful as other states consider implementing either their own health reforms or the reforms specified by the Affordable Care Act (ACA).

### KEY FINDINGS

**Coverage trends suggest that Vermont's health reform programs are an important factor in observed increases in insurance coverage for the state.**

Between 2005 and 2009, the percentage of all residents with some type of insurance coverage in Vermont increased by 2.2 percent (or 2.4 percent if the Medicare eligible population is excluded), bringing the percentage of residents covered by insurance up to 92.4 percent. Additionally, during this time period, insurance coverage in Vermont increased more rapidly than in other New England states, with most of the increase in Vermont's coverage coming through increases in public coverage.

**Most of Vermont's increase in coverage during the study period was attributable to an increase in the propensity to take up coverage rather than to a shift in demographics, and may indicate some level of crowd-out.**

There was a substantial increase in the propensity to enroll in public coverage in particular between 2005 and 2009 (4.4 %). There was also a decline in the propensity to enroll in private insurance in Vermont between 2005 and 2009 of about 1.9 percent. This decline was greater than the corresponding change in New England but not much greater than the national change (-1.5%). The larger decline seen in Vermont may suggest some level of crowd-out by public coverage; however, given the economic decline during this time period, the occurrence of crowd-out is not clear from the data.

**Take-up of Catamount Health was substantial during the initial months, and most Catamount Health enrollees qualify for premium assistance, highlighting the importance of premium subsidies in encouraging take-up among lower-income groups.**

Only 16.2 percent of enrollees have family incomes above 300 percent of the federal poverty level and do not receive premium assistance. This indicates that Catamount may not be perceived as affordable without premium subsidies. The affordability of Catamount, particularly for those individuals who do not qualify for premium assistance, was cited by interview subjects as a potential barrier to enrollment.

**Evidence suggests that outreach campaigns contributed to an increase in enrollment into existing programs among those who were previously eligible but not enrolled, indicating the critical role of outreach efforts in campaigns to increase insurance coverage.**

An aggressive outreach campaign has spread knowledge about both new and existing programs, and it has facilitated enrollment in state programs. Our analyses show that insurance coverage rates increased 5.2 percent among those who had always been eligible for public insurance. In comparison, coverage rates increased more moderately among those who were newly eligible (0.3%) or never eligible (0.4%) for public coverage. These data suggest that increased marketing and outreach to populations already eligible for public insurance in Vermont were successful in encouraging take-up among this group.

**Churning among Catamount Health enrollees is higher than expected, which may result in increased administrative expenses and reduced continuity of care among enrollees.**

Catamount's enrollment size has been steady, with enrollment growth hampered by a sizable proportion of beneficiaries leaving the program each month. An analysis of enrollment churn found that very few people stay continuously enrolled in the program, with the average duration of enrollment around 7-8 months. This finding has implications for the cost of the program in terms of administrative expense as well as for the continuity of care received by program enrollees.

**Vermont's public coverage programs, as currently funded, are not financially sustainable, pointing to the need for federal and state collaboration in funding state health care reforms.**

Vermont began to acquire revenues for health reform prior to the implementation of most of its programs. 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 Catamount Health, the Catamount Fund balance was approximately \$7.6 million. Since December 2007, the fund balance has declined as program revenues are not keeping pace with expenditures. Without legislative action during the 2010 session, the projected fund balance in August of 2010 would have been negative. (The decline in the Catamount Fund is not surprising, since the Fund relies on a cigarette tax, which is a declining revenue source, while costs to Catamount Health are outpacing inflation.) Program sustainability as a function of premium expenditures versus tax and other revenues is currently not viable in the long

term. The state considered several administrative changes that had the potential to reduce the administrative expense of the program; however, due to political opposition to these changes and due to the passage of federal health reform, the state has not made these changes to date.

## IMPLICATIONS FOR FEDERAL REFORM

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

In many ways, ACA is a reflection of Vermont's history of innovative reform, particularly in how both reform efforts utilize a hybrid of public and private insurance markets to significantly expand coverage. As a national leader in state health reform, Vermont is well-poised to use the impetus provided by ACA to further the goal of universal coverage. Already the Vermont legislature has passed legislation in support of a committee that will be tasked with exploring options for how Vermont can expand reform efforts using ACA.

As ACA implementation moves forward, several lessons can be gleaned from the findings above:

- ✓ Premium assistance appears to encourage take-up of coverage among lower-income groups, indicating that ACA's exchange subsidies are necessary for the expansion of coverage nationally.
- ✓ Concerns about churning under ACA between Medicaid and the Exchange are warranted given Vermont's experience with churning onto and off of Catamount Health. Further investigation into the impact of churning on administrative costs and continuity of care is needed in order to determine how to best address this problem going forward.
- ✓ Outreach and marketing campaigns are effective in encouraging take-up of coverage through public programs, particularly among those who are eligible but not enrolled. This is a particularly salient finding for ACA implementation given the large group of adults and children nationwide who are eligible for Medicaid/CHIP but not enrolled in coverage (Kenney, Lynch, Cook, & Phong, 2010; Holahan, Cook, & Dubay, 2007).
- ✓ States will require additional federal funding for ACA implementation and other health reform efforts going forward, as current funding mechanisms, such as that underlying Catamount Health, are unsustainable in the long term.

## CONCLUSION

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

This brief summarizes the findings from the authors' in-depth report, **Achieving Universal Health Coverage through Comprehensive Health Reform: The Vermont Experience – Report of Findings**. The full report can be found at [http://www.shadac.org/files/shadac/publications/AchievingUniversalCoverageVTFinalReport\\_0.pdf](http://www.shadac.org/files/shadac/publications/AchievingUniversalCoverageVTFinalReport_0.pdf). Additional findings from this research team are available at <http://www.shadac.org/share/grant/VermontExperience>.

## REFERENCES

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## ABOUT SHARE

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The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that supports rigorous research on health reform issues, specifically as they relate to the state implementation of the Affordable Care Act (ACA). The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. Information is available at [www.statereformevaluation.org](http://www.statereformevaluation.org).

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