Health Reform Update- October, 2011

Health Care Reform Faces the Facts: What Health Services Will Be Covered?

The new members of the Green Mountain Care Board have been busy receiving briefings and tutorials, and attending seminars, conferences and basically any form of crash course on health care and health care reform that is available in Vermont and elsewhere. This is a good thing. The tasks assigned to the Board are daunting, and the more knowledge they have, and the more knowledge they *share,* the more likely their deliberations will be grounded in actual experience and evidence rather than hope and anecdotes.

As noted in last month's article, the Board has a strong focus on cost containment and payment reforms, but lately has not been able to avoid the broader issues of what kinds of health care services ought to be covered in a health plan. This is inextricably bound with how costs might be contained*, what* will be paid for and *how* it will be paid for. But it's the Health Care Exchange scheduled to launch 1/1/2014, and *not* Green Mountain Care (the "single payer plan" scheduled to launch in 2017) that has really brought the issue of covered services to the forefront of the reform debate. A number of reform facts combined to sharpen this focus:

- Under the federal reform law (PPACA), the federal government will define an "Essential Benefits" (EB) list that establishes the minimum covered services for all state Health Insurance Exchanges. In other words, all states must cover at least the EB services.
- It was first expected the EB list would be released in Fall 2011. Recently, the feds announced the EB list won't be released until Spring 2012 at the earliest.
- In October, the Institute of Medicine(IOM)(the health care research branch of the federal government), responding to a request from the Secretary of Health and Human Services(HHS), released a report with recommendations on what should be included in the EB list. In what could be described as a policy bombshell, the IOM recommended that HHS give priority in making its final decisions on *the cost of services.* Noting that the central goal of health care reform is making affordable coverage available nationwide, the IOM suggested that HHS first set a cost target and then prioritize necessary and effective care for inclusion up to the cost target. This caused great consternation among some consumer advocates who lobby for treatments related to particular conditions and/or diseases (e.g. mental illness, autism, infertility, etc.) who are concerned their condition might be assigned a lower priority than those illnesses experienced by more citizens. Medical and surgical specialists and hospitals that focus on particular conditions and illnesses also raised objections. But IOM held firm: concerns about comprehensiveness of benefits has to be tempered by attention to cost.
- The EB list not only determines the minimum benefit for state Exchanges, it also sets a cap on what the federal government will subsidize; the subsidies for individuals and tax credits for employers are limited to the cost of premiums for the EB. That means if a state wants to add more mandated benefits to the EB for its own state Exchange plans, then the state must come up with the additional premium subsidy. As an example, if the federal EB does not include Vermont's recent mandated coverage for autism spectrum disorder services, then if Vermont wants to include that coverage in our Exchange, the state of Vermont must subsidize the higher premium that results. This means that for the first time the state government (Governor and legislature) must actually budget for the cost impact of a benefit mandate, or eliminate the mandate.
- And the cost impact could be significant: the federal law is clear that the state would have to subsidize all individuals and the employees of small businesses, who qualify for subsidies when buying through the Exchange. The Governor and legislature have indicated a desire to include all uninsured individuals,

individuals now on Catamount or in VHAP, and the employees of all businesses of up to 100 employees. (More than 100,000 people).

- The federal eligibility for subsidies is on a sliding scale up to 400% of poverty (in 2011, annual gross income of $89,400 for a family of four), well above the average household income in Vermont, so there would be a whole lot of people to subsidize. Catamount, for example, covers only around 12,000 people (eligibility is up to 300% of poverty) and costs $58 million annually. The non-federal share of that spending is $24 million. Individual premiums cover only $10 million of the cost of Catamount; the rest of the non-federal share is covered by assessments on employers, tobacco taxes and other forms of tax/fee revenues. And that's only 12,000 people.

You can do the math. It's a daunting prospect. And this is only for the Exchange. Many of us knew during the past legislative session that the real battle ground was going to be the Exchange, not Green Mountain Care. Because if we can't address the tough issues about cost containment, what's covered and how to pay for subsidies for the Exchange ---- which will be covering no more than ¼ of our population ---- how do we think we're going to finance a single payer for everyone?

Another Section of PPACA Bites the Dust

The feds just couldn't make the Long Term Care (LTC) program work. In late October, the Department of Health and Human Services announced they would not be putting further effort into implementing the Community Living Assistance Services and Supports (CLASS) program, a voluntary long-term care insurance plan included in the federal reform law.
This came as little surprise to those who've tried to promote long term care insurance in the past. Several structural flaws in the program, dictated by the legislation itself, doomed CLASS to failure, according to many industry watchers.

- ✓ Employers had the option of signing up to offer the plan, and if they did, employees could choose to opt out. The entire effort would have been voluntary.
- ✓ Voluntary long-term care insurance suffers from adverse selection; those who believe they'll need it, buy it. Those who don't, don't. The resulting risk pool drives up premiums, making the coverage even less attractive to self-perceived healthier people.
- ✓ People would be required to pay premiums for five years before drawing any benefits. This is designed to somewhat blunt the adverse selection, but made the program even less attractive.
- ✓ The benefit would be around $75/day.

It's a disappointment for advocates who wanted to see the beginning of a national LTC insurance plan (that maybe could slide into the Medicare program eventually.) But it's even more of a disappointment for state Medicaid directors, who hoped that a successful CLASS program could reduce their own expenditures on nursing home and home health care, two of the more costly benefits under state Medicaid plans. This potential reduction of Medicaid costs did contribute to the positive score garnered for PPACA from the Congressional Budget Office. Now that CLASS is sidelined, it's unclear if those figures will be adjusted.

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